

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>Frederick</b>	MARYLAND	STATE <b>Maryland</b>	COUNTY <b>Frederick</b>
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>	LENGTH OF STAY (in this place) <b>45 Years</b>	CITY (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>729 Motter Avenue</b>		STREET ADDRESS (If rural give location) <b>729 Motter Avenue</b>	
3. NAME OF DECEASED: (First) (Middle) (Last) <b>BELVA CATHERINE BOND</b>		4. DATE (Month) (Day) (Year) OF DEATH: <b>April 19, 1955</b>	
5. SEX: <b>Female</b>	6. COLOR OR RACE: <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Widow</b>	8. DATE OF BIRTH: <b>5 Sept 1887</b>
9. AGE last birthday <b>67</b> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>House-work</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country): <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME: <b>Andrew J. Stotelmayer</b>		14. MOTHER'S MAIDEN NAME: <b>Sarah A. Miller</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT & ADDRESS: <b>257 W. 5th St., Mrs. Pierce H. Gaver, Frederick, Md.</b>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <b>Carcinoma Uterus</b>			<b>3 yrs.</b>
ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>Chronic Hypertension Heart disease</b>			<b>1 yr.</b>
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. TIME (Month) (Day) (Year) (Hour) OF INJURY		21F. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <b>Apr 18, 1955</b> to <b>Apr 18, 1955</b> , that I last saw the deceased alive on <b>Apr 18, 1955</b> , and that death occurred at <b>12:45 PM</b> , from the causes and on the date stated above.			
SIGNATURE <b>A. Klein</b>		DATE SIGNED <b>19 April 1955</b>	
M.D. <b>Frederick, Maryland</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>22 April 1955</b>	
NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
DATE REC'D BY LOCAL REGISTRAR <b>19 April 1955</b>		REGISTRAR'S SIGNATURE <b>Elizabeth H. Heck</b>	
24. FUNERAL DIRECTOR <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		ADDRESS	

MARGIN RESERVED FOR BINDING

RECEIVED

APR 20 1955

BUREAU V. 2

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3649 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03636

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Frederick</b>		MARYLAND		STATE <b>Maryland</b> COUNTY <b>Carroll</b>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Frederick</b>		LENGTH OF STAY (in this place) <b>1 month</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Mt. Airy</b>		<b>068-20</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Frederick Mem. Hospital</b>				STREET ADDRESS (If rural give location) <b>Park Ave.</b>		✓	
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year) OF DEATH:			
<b>JEFFERSON R. BOONE</b>				<b>April 21, 1955</b>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR Months Days Hours Min.		
<b>male</b>	<b>white</b>	<b>married</b>	<b>2-21-1891</b>	<b>64</b> yrs.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life.) <b>Maintenance man</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>Lofstrend Co.</b>		11. BIRTHPLACE (State or foreign country): <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME: <b>Marshall Boone</b>				14. MOTHER'S MAIDEN NAME: <b>Josephine Wilson</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>no</b>		16. SOCIAL SECURITY NO. <b>216-03-8480</b>		17. INFORMANT & ADDRESS: <b>Mrs. Clara Boone, Mt. Airy, Md.</b>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <b>420.1</b>							
ANTECEDENT CAUSE (S):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST							
(A) <b>Coronary thrombosis with infarction of the myocardium.</b>				<b>5 wks.</b>			
(B) <b>Coronary arteriosclerosis</b>				<b>6 yrs +.</b>			
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>3/25, 1955</b> , to <b>4/21, 1955</b> , that I last saw the deceased alive on <b>4/21, 1955</b> , and that death occurred at <b>5:10 PM</b> , from the causes and on the date stated above.							
SIGNATURE <b>Henry V. Chase</b>				ADDRESS <b>M.D. 4 E. Church St</b>			
DATE SIGNED <b>4/21/55</b>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY		LOCATION (City, town, or county) (State)	
<b>BURIAL</b>		<b>4-24-1955</b>		<b>Linganore</b>		<b>Frederick Co. Maryland</b>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<b>23 April 1955</b>		<b>Eligible S. Herb</b>		<b>C. M. Waltz, Winfield, Maryland</b>			

RECEIVED

APR 26 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1803637  
 3672  
 CERTIFICATE OF DEATH  
 Reg. Dist. No. 139

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Frederick</b>		MARYLAND		STATE <b>Md</b>		COUNTY <b>Frederick</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Rural Foxville</b>		LENGTH OF STAY (in this place) <b>Lifetime</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Rural Foxville</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>00</b>				STREET ADDRESS (If rural give location) <b>1</b>			
3. NAME OF DECEASED: (First) <b>Harry</b> (Middle) <b>Silas</b> (Last) <b>Buhrman</b>				4. DATE (Month) (Day) (Year) OF DEATH: <b>Apr. 20. 1955</b>			
5. SEX: <b>Male</b>	6. COLOR OR RACE: <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widowed</b>	8. DATE OF BIRTH: <b>March 29th, 1883</b>	9. AGE last birthday <b>72</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>Potato raiser</b>		11. BIRTHPLACE (State or foreign country): <b>Foxville Fredk Co. Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME: <b>Sida Buhrman</b>				14. MOTHER'S MAIDEN NAME: <b>Mary Jane Buhrman</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT & ADDRESS: <b>Theodore F. Buhrman Smithsburg MD</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE <b>420.1</b> (A) <b>Heart disease, Coronary type</b> DUE TO						<b>8 mos.</b>	
ANTECEDENT CAUSE (S) (B) _____ DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) _____ DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>None</b>							
19A. DATE OF OPERATION: <b>None</b>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Aug 13</b> , 1954, to <b>Apr. 19</b> , 1955, that I last saw the deceased alive on <b>Apr. 12</b> , 1955, and that death occurred at <b>11 A.M.</b> from the causes and on the date stated above. SIGNATURE <b>James K. Gray.</b> ADDRESS <b>Thurmont Md.</b> DATE SIGNED <b>4/21/55</b>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>April 23, 1955</b>		NAME OF CEMETERY OR CREMATORY <b>United Brethern Cem.</b>		LOCATION (City, town, or county) (State) <b>Thurmont Fredk. Co. Md</b>	
DATE REC'D BY LOCAL REGISTRAR <b>4/22/55</b>		REGISTRAR'S SIGNATURE <b>[Signature]</b>		24. FUNERAL DIRECTOR ADDRESS <b>A. L. Creager &amp; Son Thurmont. Md</b>			

BUREAU V.S.

APR 25 1955

RECEIVED



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03638

3650

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Frederick</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Frederick</u>		LENGTH OF STAY (in this place) <u>Years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick-Rural R.F.D.#3</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Frederick Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>Yellow Springs</u> /			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>THOMAS RICHARD CANNON</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>April 6, 1955</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, <del>DIVORCED</del> , (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>March 6, 1916</u>	9. AGE last birthday <u>39</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Press Operator</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>Aluminum Co.</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME: <u>Roy A. Cannon</u>				14. MOTHER'S MAIDEN NAME: <u>Bertha M. Linton</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-10-3577</u>		17. INFORMANT & ADDRESS: <u>Mrs. Glendora S. Cannon, Frederick R.D.#3, Md</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>593X</u>							
IMMEDIATE CAUSE (A) <u>Malignant Hypertension</u>						<u>4 yrs +</u>	
ANTECEDENT CAUSE (B) <u>Nephritis</u>						<u>4 yrs +</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May</u> , 195 <u>4</u> , to <u>April 6</u> , 195 <u>5</u> , that I last saw the deceased alive on <u>April 6, 1955</u> , and that death occurred at <u>3:45 P.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		M. D. <u>Frederick, Maryland</u>		ADDRESS <u>Frederick County, Maryland</u>		DATE SIGNED <u>4/7/1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Apr. 9, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Pleasant Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Frederick County, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>April 9, 1955</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR ADDRESS <u>M. R. Etchison &amp; Son, Frederick, Maryland</u>			

BUREAU V. S.

APR 12 1955

RECEIVED



3673

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

## 1. PLACE OF DEATH:

COUNTY Frederick MARYLAND  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR TOWN Libertytown LENGTH OF STAY (in this place) 2 years  
 HOSPITAL OR INSTITUTION OR STREET ADDRESS 00

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Frederick  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR TOWN Libertytown STREET ADDRESS (If rural give location) 1

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

4. DATE OF DEATH:

(Month)

(Day)

(Year)

## 5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

## 8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR

IF UNDER 24 HRS.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired:

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

## 13. FATHER'S NAME:

## 14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT &amp; ADDRESS:

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X  
Immediate cause

(a)

DUE TO

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

DUE TO

(c)

Interval Between Onset And Death

7 days

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☐

## 21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1954, to April, 1955, that I last saw the deceased alive on 4-1-, 1955, and that death occurred at 2:05 AM, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 12 1955

RECEIVED

3651

## CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>Frederick</b>	MARYLAND	STATE <b>MARYLAND</b>	COUNTY <b>Frederick</b>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Frederick</b>	LENGTH OF STAY (If in this place) <b>25 yrs</b>	CITY (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>	TOWN <b>Frederick</b>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>1611 Rosemont Ave</b>		STREET ADDRESS (If rural give location) <b>1611 Rosemont Ave</b>	
3. NAME OF DECEASED: (First) <b>Bessie</b> (Middle) <b>Lee</b> (Last) <b>Dubel</b>		4. DATE OF DEATH: (Month) <b>April</b> (Day) <b>21</b> (Year) <b>1955</b>	
5. SEX: <b>Female</b>	6. COLOR OR RACE: <b>White</b>	7. <del>SINGLE</del> MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH: <b>Aug. 22. 1887</b>
9. AGE last birthday: <b>67</b> yrs.		10. AGE last birthday: If UNDER 1 YEAR   If UNDER 24 HRS. Month. Days Hours Min.	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY: <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country): <b>Frederick Co. MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME: <b>Jacob V McDonald</b>		14. MOTHER'S MAIDEN NAME: <b>Clara V Routzahn</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>No</b> (If Yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY No.: <b>No</b>	
17. INFORMANT & ADDRESS: <b>James N. Dubel 1611 Rosemont Ave. Fred</b>			

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) <b>Subarachnoid hemorrhage</b>		<b>4 days</b>
Immediate cause DUE TO		
(b) <b>Hypertensive Cardiovascular disease</b>		
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO		
(c) <b>with healed dissecting aortic aneurysm</b>		<b>3 yrs +</b>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
	INJURY			
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <b>4/17</b> , 1955, to <b>4/21</b> , 1955, that I last saw the deceased alive on <b>4/20</b> , 1955, and that death occurred at <b>2 AM</b> , from the causes and on the date stated above.				
SIGNATURE <b>Henry V Chase M.D.</b>		ADDRESS <b>45 Church St</b>		DATE SIGNED <b>4/21/55</b>
23. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	DATE THEREOF <b>Apr. 25. 1955</b>	NAME OF CEMETERY OR CREMATORY <b>Mt Olivet Cem.</b>	LOCATION (City, town, or county) <b>Frederick</b>	(State) <b>MD</b>
DATE RECD BY LOCAL REGISTRAR <b>23 April 1955</b>	REGISTRAR'S SIGNATURE <b>Elizabeth G. Heib.</b>	24. FUNERAL DIRECTOR <b>M. L. Creager &amp; Son</b> ADDRESS <b>Thurmont. MD</b>		

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR

RECORDED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03641

3652

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		LENGTH OF STAY (in this place) <u>9 days</u>		If outside corporate limits, write RURAL and give nearest town) <u>Walkersville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Fred. Memorial Hosp.</u>				STREET ADDRESS (If rural give location) <u>Walkersville</u>			
3. NAME OF DECEASED: (First) <u>MILTON</u> (Middle) <u>—</u> (Last) <u>EYLER</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>April 8 1955</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>Nov. 2, 1869</u>	9. AGE last birthday <u>86</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Farmer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Own farm</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Martin Eyer</u>				14. MOTHER'S MAIDEN NAME: <u>Catherine Eyer</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS: <u>Mrs. Milton Eyer, Walkersville, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Hemorrhage</u>						9 days	
ANTECEDENT CAUSE (S) <u>Prostate hypertrophy</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (B) <u>Cardiac decompensation</u>						7 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. (C) <u>Cardiac decompensation</u>							
19A. DATE OF OPERATION: <u>4/6/55</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Bleeding from prostate gland</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 30th</u> , 1955, to <u>Apr. 8</u> , 1955, that I last saw the deceased alive on <u>Apr. 8</u> , 1955, and that death occurred at <u>4:45 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Marcell Belt</u>		ADDRESS <u>Frederick, Md.</u>		DATE SIGNED <u>Apr. 9 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4/11/55</u>		NAME OF CEMETERY OR CREMATORY <u>Glade Cemetery</u>		LOCATION (City, town, or county) (State) <u>Walkersville, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>9 April 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth G. Herb.</u>		24. FUNERAL DIRECTOR <u>G.C. Barton</u>		ADDRESS <u>Walkersville, Md.</u>	





3653

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>Frederick</b>	MARYLAND	STATE <b>md</b>	COUNTY <b>Frederick</b>
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>	LENGTH OF STAY (in this place) <b>8 hr.</b>	CITY (If outside corporate limits, write RURAL and give nearest town) <b>Thurmont</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Frederick Mem. Hospital</b>		STREET ADDRESS (If rural give location) <b>/</b>	

3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <b>Charles</b>	(Middle) <b>Ralph</b>	(Last) <b>Fornwald</b>	(Month) <b>Apr.</b> (Day) <b>16.</b> (Year) <b>1955</b>
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:
<b>Male</b>	<b>White</b>	<b>Married</b>	<b>Nov. 24. 1875</b>
9. AGE last birthday:		10. BIRTHPLACE (State or foreign country):	
<b>79</b> yrs. Month. Days Hours Min.		<b>Reading Penna</b>	
11. USUAL OCCUPATION Give kind of work done during most of working life, even if retired		12. CITIZEN OF WHAT COUNTRY?	
<b>Navy Yard Employee (retired)</b>		<b>U.S.A</b>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<b>Wm. Fornwald</b>		<b>Hattie Rhodes</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:	
<b>No</b>		<b>No</b>	
17. INFORMANT & ADDRESS:			
<b>Ralph E. Fornwald</b>		<b>Thurmont Md</b>	

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <b>Cerebral Hemorrhage</b>		<b>18 hours</b>
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.		<b>several years</b>
(b) <b>Arteriosclerotic Cardiovascular Disease</b>		
(c) <b>Diabetes Mellitus</b>		<b>several years</b>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<b>20 AUTOPSY ?</b>
19a. DATE OF OPERATION:		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
19b. MAJOR FINDINGS OF OPERATION		
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
	INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from <b>4/15</b> , 19 <b>55</b> , to <b>4/16</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>4/16</b> , 19 <b>55</b> , and that death occurred at <b>6:30 AM</b> , from the causes and on the date stated above.			
SIGNATURE <b>E. D. [Signature]</b>		DATE SIGNED <b>4/16/55</b>	
23. BURIAL, CREMATION, REMOVAL (Specify)		NAME OF CEMETERY OR CREMATORY	
<b>Burial</b>		<b>Blue Ridge Cem.</b>	
DATE REC'D BY LOCAL REGISTRAR		LOCATION (City, town, or county) (State)	
<b>18 April 1955</b>		<b>Thurmont Fredk CO. Md</b>	
REGISTRAR'S SIGNATURE <b>Elizabeth L. [Signature]</b>		24. FUNERAL DIRECTOR ADDRESS	
		<b>M.L. Creager &amp; Son Thurmont MD</b>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

EDWARD A. S.

APR

3674  
CERTIFICATE OF DEATH

Reg. Dist. No. 144

1. PLACE OF DEATH: COUNTY <b>Frederick</b> CITY (If outside corporate limits, write RURAL and give nearest town) <b>Rural Thurmont</b> TOWN <b>Rural Thurmont</b> HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>00</b>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <b>MD</b> COUNTY <b>Frederick</b> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Rural Thurmont</b> STREET ADDRESS (If rural give location) <b>1</b>	
3. NAME OF DECEASED: (Type or Print) <b>Emma Jane Freshman</b>		4. DATE OF DEATH: (Month) (Day) (Year) <b>April 13 1955</b>	
5. SEX: <b>Female</b>	6. COLOR OR RACE: <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH: <b>Feb 5th. 1877</b>
9. AGE last birthday: <b>78</b> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country): <b>Thurmont R.D. Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME: <b>John T. Brice</b>		14. MOTHER'S MAIDEN NAME: <b>Arabella</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY No. <b>No</b>	
17. INFORMANT & ADDRESS: <b>Martin L. Freshman Thurmont. MD</b>			
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <b>2-1X</b> IMMEDIATE CAUSE (A) <b>Cerebral Hemorrhage</b> DUE TO ANTECEDENT CAUSE (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <b>(904.7)</b> DUE TO C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>Fracture of L. hip.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7 mos.</b> <b>5 mos.</b>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>Sept 15, 1954</b> to <b>Apr. 13, 1955</b> , that I last saw the deceased alive on <b>Apr. 13, 1955</b> and that death occurred at <b>3:30 P.M.</b> , from the causes and on the date stated above. SIGNATURE <b>James K. Gray</b> M.D. <b>Thurmont Md.</b> DATE SIGNED <b>Apr. 14-1955</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Apr. 16th. 1955</b>	
NAME OF CEMETERY OR CREMATORY <b>U.B. Cemetery</b>		LOCATION (City, town, or county) (State) <b>Thurmont. Fredk Co. MD</b>	
DATE REC'D BY LOCAL REGISTRAR <b>April 15/1955</b>		REGISTRAR'S SIGNATURE <b>Blanche S. Eyles</b>	
24. FUNERAL DIRECTOR <b>A.L. Creager &amp; Son</b>		ADDRESS <b>Thurmont MD</b>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

W. A. L. 11/11/11

11/11/11

3675  
CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Frederick	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Frederick-Rural R.D. #1		Months		OR TOWN Frederick-Rural R.D. #1		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
Near Walkersville,				Near Walkersville			
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year)			
(First) MARGARET		(Middle) ELLEN		(Last) GEISBERT		DATE OF DEATH: April 20, 1955	
5. SEX: Female		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow		8. DATE OF BIRTH: January 30, 1874	
				9. AGE last birthday: 81 yrs		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework				10B. KIND OF BUSINESS OR INDUSTRY: Home		11. BIRTHPLACE (State or foreign country): Maryland	
						12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: William Snauffer				14. MOTHER'S MAIDEN NAME: Elizabeth Shaffer			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS: Stuart L. Geisbert, Frederick, R.F.D. #1, Md	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE 443X							
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) Myocardial infarction due to atherosclerosis							
(B) Generalized arteriosclerosis							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 10-1, 1954, to 4-20, 1955 that I last saw the deceased alive on 4-19, 1955, and that death occurred at 4:30 M, from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
R. D. Martin		Frederick, Maryland		4/21/1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Apr. 23, 1955		Methodist Cemetery		Urbana, Maryland	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
21 April 1955		Elizabeth B. Hark		M. R. Etchison & Son		Frederick, Maryland	

MARGIN RESERVED FOR BINDING

RECEIVED

APR 22 1955

AMERICAN



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03645

## 3676 CERTIFICATE OF DEATH

Reg. Dist. No. 145

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>Ma.</u>		COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Myersville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year) OF DEATH:			
(First) <u>Alta</u>		(Middle) <u>V.</u>		(Last) <u>Grossnickle</u>		4 4 1955	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
<u>Female</u>	<u>white</u>	<u>widow</u>	<u>9-1-1876</u>	<u>78</u> yrs.			
13. FATHER'S NAME:			14. MOTHER'S MAIDEN NAME:			15. CITIZEN OF WHAT COUNTRY?	
<u>Ezra Harshman</u>			<u>Louise Leatherman</u>			<u>U.S.</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)			17. SOCIAL SECURITY NO.			18. INFORMANT & ADDRESS:	
<u>no</u>			<u>none</u>			<u>Joseph Grossnickle, Middletown, Md.</u>	
19. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							15 min
420.1 IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>							
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Arteriosclerosis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:			19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>Nov</u> 1954, to <u>Apr. 4</u> , 1955, that I last saw the deceased alive on <u>Mar 31</u> , 1955, and that death occurred at <u>9:10 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>J E Harp</u>			ADDRESS <u>M. D. Middletown</u>		DATE SIGNED <u>4-5-55</u>		
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>4-6-1955</u>		<u>U.B. Cemetery</u>		<u>Myersville Md</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>April 6-1955</u>		<u>Shoy M. Bittle</u>		<u>Gladhill Co., Middletown, Md.</u>			

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## 3677 CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>Frederick</b>	MARYLAND	STATE <b>Maryland</b>	COUNTY <b>Frederick</b>
<del>CITY</del> (If outside corporate limits, write RURAL and give nearest town)		<del>CITY</del> (If outside corporate limits, write RURAL and give nearest town)	
X TOWN <b>Doubs</b>	LENGTH OF STAY (in this place) <b>Years</b>	TOWN <b>Doubs</b>	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<b>IDA BELL HAWES</b>		OF DEATH: <b>April 8, 19 55</b>	
5. SEX. <b>Female</b>	6. COLOR OR RACE: <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <b>Widow</b>	8. DATE OF BIRTH: <b>February 3, 1878</b>
9. AGE last birthday <b>77</b> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
		Months	Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Housework</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>Home</b>	11. BIRTHPLACE (State or foreign country): <b>Virginia</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME: <b>George F. Heffner</b>	
14. MOTHER'S MAIDEN NAME: <b>Margaret Shafer</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.): <b>No</b> (If Yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT & ADDRESS: <b>Mrs. Millard Wilt, Doubs, Maryland</b>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <b>Probable Coronary Occlusion</b>			<b>15 min</b>
DUE TO			
ANTECEDENT CAUSE (B) <b>Acute Myocardial Infarction</b>			<b>15 min</b>
DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C) <b>Myocardial Infarction - Primary site undetermined</b>			<b>4 mo</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>Nov 3, 1954</b> to <b>3/6, 1955</b> that I last saw the deceased alive on <b>3/6, 1955</b> , and that death occurred at <b>8:55 P.M.</b> , from the causes and on the date stated above.			
SIGNATURE <b>C. Belton Brice</b>		ADDRESS <b>Jefferson, Maryland</b>	
DATE SIGNED <b>4/9/1955</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Apr. 11, 1955</b>	
NAME OF CEMETERY OR CREMATORY <b>Union Cemetery</b>		LOCATION (City, town, or county) (State) <b>Lovettsville, Virginia</b>	
DATE REC'D BY LOCAL REGISTRAR <b>April 9, 1955</b>		REGISTRAR'S SIGNATURE <b>Elizabeth S. Hesk.</b>	
24. FUNERAL DIRECTOR <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		ADDRESS	

MARGIN RESERVED FOR BINDING

BUNNELL V. S.

107

Case No. 107

3673

## CERTIFICATE OF DEATH

Reg. Dist. No. 145

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Frederick</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>Fred.</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Myersville</i>		<i>2 weeks</i>		TOWN <i>Hofferville</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
70				1			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year) OF DEATH:			
(First) (Middle) (Last) <i>Albert E. Hays</i>				<i>4 18 1955</i>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<i>male</i>	<i>white</i>	<i>married</i>	<i>1-11-1874</i>	<i>81</i> yrs	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?
<i>farm owner</i>			<i>farm</i>		<i>Maryland</i>		<i>U.S.</i>
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<i>John O. Hays</i>				<i>Catherine S. Fox</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<i>no</i>				<i>none</i>		<i>Mrs. Samuel Rutzahn, Myersville, Md.</i>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>Cardio-Renal-Vascular disease</i>						<i>4 yrs.</i>	
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
		M.					
22. I hereby certify that I attended the deceased from <i>Aug - 1950</i> , to <i>April 18, 1955</i> , that I last saw the deceased alive on <i>Apr 17 55</i> , 19.., and that death occurred at <i>4:50 AM</i> , from the causes and on the date stated above.							
SIGNATURE <i>J. E. Harp</i>		ADDRESS <i>Middletown</i>		DATE SIGNED <i>4-19-55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>4-20-1955</i>		<i>Lutheran Cemetery</i>		<i>Hofferville Md.</i>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		FUNERAL DIRECTOR		ADDRESS	
<i>April 20-55</i>		<i>Floy M. Bittle</i>		<i>Bladhill Co., Middletown, Md.</i>			

MARGIN RESERVED FOR BINDING

APR 22 1965

RECEIVED



03648

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 145

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>FREDERICK</b>		MARYLAND		STATE <b>MARYLAND</b> COUNTY <b>FREDERICK</b>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
<b>X TOWN NR. SMITHSBURG</b>		<b>LIFE</b>		<b>TOWN NR. SMITHSBURG</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>RD #1</b>				STREET ADDRESS (If rural, give location) <b>RD #1</b>			
3. NAME OF DECEASED: (First) <b>WILLIAM</b>		(Middle) <b>TECUMSEH</b>		(Last) <b>HAYS</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>APRIL 17, 1955</b>	
5. SEX: <b>MALE</b>	6. COLOR OR RACE: <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>MARRIED</b>	8. DATE OF BIRTH: <b>MARCH 8, 1883</b>		9. AGE last birthday: <b>72</b> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY: <b>FARM-QUARRY</b>		11. BIRTHPLACE (State or foreign country): <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME: <b>HENRY CLAY HAYS</b>				14. MOTHER'S MAIDEN NAME: <b>SUSAN JOHNSON</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY No.: <b>213-18-0742</b>		17. INFORMANT & ADDRESS: <b>ALMA HAYS, RD #1 NR. SMITHSBURG, MD.</b>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <b>ACUTE MYOCARDIAL INFARCTION</b>		DUE TO		<b>1 DAY</b>	
Antecedent cause(s) (b) <b>ARTERIO SCLEROTIC HEART DISEASE</b>		DUE TO			
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <b>None</b>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>M.</b>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <b>Robert J. J. J.</b>		CHIEF MEDICAL EXAMINER		DATE SIGNED <b>4-17-55</b>	
		DEPUTY MEDICAL EXAMINER			
		ASSISTANT MEDICAL EXAM.			
23. BURIAL, CREMATION, REMOVAL (Specify): <b>BURIAL</b>		DATE THEREOF: <b>APRIL 19, 1955</b>		NAME OF CEMETERY OR CREMATORY: <b>U. B. GARFIELD</b>	
LOCATION (City, town, or county) (State): <b>GARFIELD-FREDERICK, MD.</b>		24. FUNERAL DIRECTOR: <b>PAUL F. BITTLE, Myersville, Md.</b>		ADDRESS:	
DATE REC'D BY LOCAL REG. <b>APR 18, 1955</b>		REGISTRAR'S SIGNATURE: <b>Edoy M. Bittle</b>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the uses of death clearly and legibly.

1791

51

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3654

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

03649

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>Frederick</b>	MARYLAND	STATE <b>Maryland</b>	COUNTY <b>Frederick</b>
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>	LENGTH OF STAY (in this place) <b>Since 2/10/55</b>	CITY (If outside corporate limits, write RURAL and give nearest town) <b>Frederick-Rural RD#5</b>	<b>X</b>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>708 North Market Street</b>		STREET ADDRESS (If rural give location) <b>Rocky Springs</b>	<b>/</b>
3. NAME OF DECEASED: (Type or Print)		4. DATE OF DEATH:	
(First) <b>MARY</b>	(Middle) <b>ELIZABETH</b>	(Last) <b>HILDEBRAND</b>	(Month) <b>April 20,</b> (Day) <b>1955</b> (Year)
5. SEX: <b>Female</b>	6. COLOR OR RACE: <b>White</b>	7. SINGLE, MARRIED, WIDOWED, <del>DECEASED</del> (Specify): <b>Widow</b>	8. DATE OF BIRTH: <b>8 June 1870</b>
		9. AGE last birthday: <b>84</b> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>House-work</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>Own Home</b>	11. BIRTHPLACE (State or foreign country): <b>Maryland</b>
13. FATHER'S NAME: <b>Edward Stup</b>		14. MOTHER'S MAIDEN NAME: <b>Victoria Wickham</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <b>No</b> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.: <b>None</b>	
17. INFORMANT & ADDRESS: <b>W. Sherwood Hildebrand, RD#5, Frederick, Md.</b>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <b>Carcinoma stomach</b>			<b>9 months</b>
ANTECEDENT CAUSE (B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Jan 1, 1952, to April 20, 1955, that I last saw the deceased alive on April 19, 1955, and that death occurred at 3:20 P M, from the causes and on the date stated above.			
SIGNATURE <b>Isornard P. Thomas Jr.</b>		ADDRESS <b>M.D. Frederick, Maryland</b>	
DATE SIGNED <b>22 April 1955</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY): <b>Burial</b>		DATE THEREOF <b>23 Apr 1955</b>	
NAME OF CEMETERY OR CREMATORY <b>Rocky Springs Cemetery</b>		LOCATION (City, town, or county) (State) <b>Frederick County Maryland</b>	
DATE REC'D BY LOCAL REGISTRAR <b>22 April 1955</b>		REGISTRAR'S SIGNATURE <b>Elizabeth B. Hecker</b>	
24. FUNERAL DIRECTOR <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		ADDRESS	

RECEIVED V. S.

APR 25 1955

U.S. DEPT. OF JUSTICE

3680

## CERTIFICATE OF DEATH

Reg. Dist. No. 138

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Frederick</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Frederick</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Rural* Mt. Airy</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Mt. Airy</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Penn Shop Rd.</b>				STREET ADDRESS <b>Penn Shop Rd.</b>			
3. NAME OF DECEASED: (First) (Middle) (Last) <b>Dollie D. Hilderbrand</b>				4. DATE OF DEATH: (Month) (Day) (Year) <b>April 11 1955</b>			
5. SEX: <b>Female</b>		6. COLOR OR RACE: <b>White</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widowed</b>		8. DATE OF BIRTH: <b>July 20, 1877</b>	
				9. AGE last birthday: <b>77</b> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY: <b>Own Home</b>		11. BIRTHPLACE (State or foreign country): <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME: <b>James W. Barrett</b>				14. MOTHER'S MAIDEN NAME: <b>Anna E. Harper</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY No.: <b>----</b>		17. INFORMANT & ADDRESS: <b>Mrs John Phoebus, Mt. Airy, Md.</b>			

18. MEDICAL CERTIFICATION				Interval Between Onset And Death	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <b>420.0</b> Immediate cause (a) <b>Arteriosclerotic Heart Disease</b> Antecedent causes (s) (b) <b>Arteriosclerosis, Generalized</b> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <b>DUE TO</b>				<b>Over 10 years</b> <b>over 10 years</b>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION: <b>—</b>				19b. MAJOR FINDINGS OF OPERATION: <b>—</b>	
21. ACCIDENT SUICIDE HOMICIDE (Specify) <b>N.</b>		PLACE (Home, farm, factory, street, office bldg., etc.) <b>—</b>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <b>—</b>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>		HOW DID INJURY OCCUR? <b>—</b>	
22. I hereby certify that I attended the deceased from <b>3/24</b> , 19 <b>55</b> , to <b>4/11</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>4/11</b> , 19 <b>55</b> , and that death occurred at <b>3:50 P.M.</b> , from the causes and on the date stated above. SIGNATURE <b>William J. Meenan, M.D.</b> (Degree or title) ADDRESS <b>% Boyer Clinic, Damascus, Md. 4/13/55</b> DATE SIGNED					
23. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		DATE THEREOF <b>Apr. 14, 1955</b>		NAME OF CEMETERY OR CREMATORY <b>St. Pauls</b>	
DATE REC'D BY LOCAL REGISTRAR <b>4-13-55</b>		REGISTRAR'S SIGNATURE <b>Raymond L. Day</b>		24. FUNERAL DIRECTOR <b>Cliff L. Molesworth, Damascus, Md.</b>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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3681

03651  
Reg. Dist. No. 147

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

<b>1. PLACE OF DEATH:</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b>	
COUNTY <u>FREDERICK</u>	MARYLAND	STATE <u>MARYLAND</u>	COUNTY <u>FREDERICK</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)		CITY (If outside corporate limits write RURAL and give nearest town)	
X TOWN <u>RURAL - MT. AIRY</u>	LENGTH OF STAY (in this place) <u>5 YRS.</u>	TOWN <u>RURAL - MT. AIRY</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>ROUTE 4</u>		STREET ADDRESS (If rural, give location) <u>RFD 4</u>	
<b>3. NAME OF DECEASED:</b> (First) <u>MILDRED</u> (Middle) <u>ROSE</u> (Last) <u>HOOPER</u>		<b>4. DATE OF DEATH</b> (Month) <u>APRIL</u> (Day) <u>16</u> (Year) <u>1955</u>	
<b>5. SEX:</b> <u>FEMALE</u>	<b>6. COLOR OR RACE:</b> <u>WHITE</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):</b> <u>MARRIED</u>	<b>8. DATE OF BIRTH:</b> <u>8-28-1885</u>
<b>9. AGE last birthday:</b> <u>69</u> yrs.		<b>10. IF UNDER 1 YEAR</b> (Months) <u>0</u> (Days) <u>0</u> (Hours) <u>0</u> (Min.)	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of work life, even if retired): <u>HOUSEWIFE</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY:</b> <u>AT HOME</u>	
<b>11. BIRTHPLACE</b> (State or foreign country): <u>MARYLAND</u>		<b>12. CITIZEN OF WHAT COUNTRY:</b> <u>USA</u>	
<b>13. FATHER'S NAME:</b> <u>JACOB STITELY</u>		<b>14. MOTHER'S MAIDEN NAME:</b> <u>ANNIE</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY No.:</b> <u>NONE</u>	
<b>17. INFORMANT &amp; ADDRESS:</b> <u>HARRY A. STITELY, BROTHER, RFD 4, MT. AIRY, MD.</u>			

<b>18. MEDICAL CERTIFICATION</b>			<b>INTERVAL BETWEEN ONSET AND DEATH</b>
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:</b>			
<u>331 X</u> Immediate cause (a) <u>CEREBRAL HEMORRHAGE</u> DUE TO			<u>1 HR.</u>
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)			
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>			
<b>19a. DATE OF OPERATION:</b>		<b>19b. MAJOR FINDING OF OPERATION:</b>	
<b>21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/></b> <u>NONE</u>	<b>21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY</b>	<b>21c. (City or town)</b>	<b>(County)</b>
<b>21d. TIME (Month) (Day) (Year) (Hour) OF INJURY</b>	<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>21f. HOW DID INJURY OCCUR?</b>	
<b>22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b>			
<b>SIGNATURE</b> <u>Robert J. Janie</u>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>DATE SIGNED</b> <u>4-16-55</u>	
<b>23. BURIAL, CREMATION, REMOVAL (Specify):</b> <u>CREMATION</u>		<b>DATE THEREOF</b> <u>4-18-1955</u>	
<b>NAME OF CEMETERY OR CREMATORY</b> <u>Locust Grove</u>		<b>LOCATION (City, town, or county)</b> <u>Fred. Co. MARYLAND</u>	
<b>DATE REC'D BY LOCAL REG</b> <u>April 18, 1955</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Robert J. Janie</u>	
<b>24. FUNERAL DIRECTOR</b> <u>J. M. Waltz</u>		<b>ADDRESS</b> <u>Winfield, Md.</u>	

BOEING V. E.

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3682

CERTIFICATE OF DEATH

Reg. Dist. No. 140

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Woodsboro</u>		<u>6 mo. 14 days</u>		OR TOWN <u>Woodsboro</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
100				1			
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year) OF DEATH:			
(First) <u>EDITH</u>		(Middle) <u>LILLY</u>		(Last) <u>KEENEY</u>		<u>April 13 1955</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <u>Sept. 29, 1954</u>	9. AGE last birthday: <u>6</u> yrs. <u>14</u> months <u>14</u> days	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):			10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Charles Luther Keeneey</u>				14. MOTHER'S MAIDEN NAME: <u>Emma Gruber</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.:		17. INFORMANT & ADDRESS: <u>Mr. Charles L. Keeneey, Woodsboro, md</u>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				754.4			
IMMEDIATE CAUSE				(A) <u>congenital heart disease, type</u>			
ANTECEDENT CAUSE (S)				DUE TO <u>undetermined</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(B) DUE TO			
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>hematoma &amp; malnutrition</u>							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Mar 14 1955</u> to <u>13 April 1955</u> , that I last saw the deceased alive on <u>14 March 1955</u> and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>James S. Hanes Jr M.D.</u>		ADDRESS <u>Waldenville, Md</u>		DATE SIGNED <u>14 April 55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4/15/55</u>		NAME OF CEMETERY OR CREMATORY <u>mt. Hope</u>		LOCATION (City, town, or county) (State) <u>Woodsboro md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4/14/55</u>		REGISTRAR'S SIGNATURE <u>E. C. Pounce</u>		24. FUNERAL DIRECTOR <u>G. C. Barton, Waldenville, md.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2-9422-2361  
VS. A15-10-53

RECEIVED

APR 21 1971

1971

3684

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<u>X</u> <u>Town</u> <u>Frederick-Rural RD#5</u>		<u>3 Weeks</u>		<u>Town</u> <u>Frederick</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Shookstown</u>				STREET ADDRESS (If rural give location) <u>718 Motter Avenue</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>MARY</u> <u>MILLER</u> <u>KEHNE</u>				OF DEATH: <u>April 25</u> , <u>19 55</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>24 March 1892</u>	
9. AGE last birthday: <u>63</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY: <u>House-wife</u>		11. BIRTHPLACE (State or foreign country): <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Amos Strausbaugh</u>				14. MOTHER'S MAIDEN NAME: <u>Rose Lease</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO: <u>None</u>			
17. INFORMANT & ADDRESS: <u>718 Motter Ave., Dallas W. Kehne, Sr., Frederick, Md.</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Acute Congestive Heart Failure</u>						<u>1 day</u>	
ANTECEDENT CAUSE (B) <u>Arteriosclerotic Heart Disease</u>						<u>1 year</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Chronic Congestive Heart Failure</u>						<u>1 month</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5 Apr</u> , 19 <u>55</u> , to <u>25 Apr</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>25 Apr</u> , 19 <u>55</u> , and that death occurred at <u>3 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Theresa C. Shaw</u>		ADDRESS <u>Frederick, Maryland</u>		DATE SIGNED <u>26 April 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Apr. 28, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>		LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>28 April 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth G. Hebb</u>		24. FUNERAL DIRECTOR ADDRESS <u>M. R. Etchison &amp; Son, Frederick, Maryland</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

S. A. 1777777

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1777777

3685

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

03654

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Frederick</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <del>Town</del> <u>Frederick-Rural-R.D.#4</u> LENGTH OF STAY (in this place) <u>Years</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Willis Derr Road</u>			STATE <u>Maryland</u> COUNTY <u>Frederick</u> CITY (If outside corporate limits, write RURAL and give nearest town) <del>Town</del> <u>Frederick R.D.#4-Rural</u> X STREET ADDRESS (If rural give location) <u>Willis Derr Road</u>		
3. NAME OF DECEASED: (First) (Middle) (Last)			4. DATE (Month) (Day) (Year) OF DEATH:		
<u>HESTER ANNIE KEMP</u>			<u>April 26, 1955</u>		
5. SEX.	6. COLOR OR RACE:	7. <del>SINGLE</del> MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR Months Days Hours Min.
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>May 7, 1886</u>	<u>68</u> yrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
<u>Housewife</u>			<u>Home</u>	<u>Maryland</u>	<u>USA</u>
13. FATHER'S NAME:			14. MOTHER'S MAIDEN NAME:		
<u>James A. Taylor</u>			<u>Ida Stockman</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS.	
<u>No</u>			<u>None</u>	<u>Charles W. Kemp, Frederick, R.D.#4, Md.</u>	
18. MEDICAL CERTIFICATION					
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
<u>420.</u> IMMEDIATE CAUSE (A) <u>Heart disease</u> ANTECEDENT CAUSE (B) <u>Coronary artery disease</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Coronary artery disease</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19A. DATE OF OPERATION:			19B. MAJOR FINDINGS OF OPERATION		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21B. PLACE (Home, farm, factory or INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>4/16</u> , 19 <u>55</u> , to <u>4/26</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4/26</u> , 19 <u>55</u> , and that death occurred at <u>10:10 M.</u> , from the causes and on the date stated above.					
SIGNATURE <u>[Signature]</u>			ADDRESS <u>Frederick, Maryland</u>		DATE SIGNED <u>4/28/1955</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY)			DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>			<u>Apr. 29, 1955</u>	<u>St. Luke's Cemetery</u>	<u>Feagaville, Maryland</u>
DATE REC'D BY LOCAL REGISTRAR			REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS	
<u>29 April 1955</u>			<u>Elizabeth G. Heeb</u>	<u>M. R. Etchison &amp; Son, Frederick, Maryland</u>	

MARGIN RESERVED FOR BINDING

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3686

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY	Frederick	STATE	Maryland
MARYLAND		COUNTY	Frederick
(If outside corporate limits, write RURAL and give nearest town)		(If outside corporate limits, write RURAL and give nearest town)	
OR TOWN	Buckeystown	OR TOWN	Buckeystown
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	

3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First)	(Middle)	(Month)	(Day)
Margaret	Louise	April	11
(Last)	Lee	(Year)	19 55
5. SEX:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	
Female	White	Married	
6. COLOR OR RACE:		8. DATE OF BIRTH:	
White		4-10-1884	
9. AGE last birthday:		10. KIND OF BUSINESS OR INDUSTRY:	
71 yrs.		Own Home	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Maryland		USA	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
Augustus Wilson		Annie Barnum	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:	
No		None	
17. INFORMANT & ADDRESS:		J. Tyson Lee—(Son) Urbana— Maryland	

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) Ventricular Fibrillation (?)		Immediate
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Arterio-sclerotic heart dis. w/auricular Fibrillation		7 year
(c)		

11. OTHER SIGNIFICANT CONDITIONS		1 month
Conditions contributing to the death but not related to the disease or condition causing death.		
Cerebral and pulmonary emboli		
19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY ?
		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4:10 P.M., 1947, to 11 April, 1955, that I last saw the deceased alive on 10 April, 1955, and that death occurred at 5:20 A.M., from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
Charles H. Conley, Jr. M.D.		Frederick Maryland 12 April 1955.	
23. BURIAL, CREMATION, REMOVAL (Specify)		NAME OF CEMETERY OR CREMATORY	
Burial		Carrollton Manor Cemetery	
DATE REC'D BY LOCAL REGISTRAR		LOCATION (City, town, or county) (State)	
12 April 1955		Nr. Buckeystown— Maryland	
REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR	
Elizabeth G. Heik.		C.E.Cline and Son— Frederick— Maryland	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

S. A. O'NEILL

SEAL

1881



3655

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>Frederick</b>	MARYLAND	STATE <b>Md</b>	COUNTY <b>Frederick</b>
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>	LENGTH OF STAY (in this place) <b>1 week</b>	CITY (If outside corporate limits, write RURAL and give nearest town) <b>Thurmont</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Fredk. Memorial Hospital</b>		STREET ADDRESS (If rural give location) <b>Thurmont</b>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <b>Edgar</b>	(Middle) <b>Russell</b>	(Last) <b>Lewis</b>	(Month) <b>Apr.</b> (Day) <b>19.</b> (Year) <b>1955</b>
5. SEX: <b>Male</b>	6. COLOR OR RACE: <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Married</b>	8. DATE OF BIRTH: <b>Apr. 17. 1892</b>
9. AGE last birthday: <b>63</b> yrs. Months Days Hours Min.		10. BIRTHPLACE (State or foreign country): <b>Frederick CO. MD</b>	
11. USUAL OCCUPATION Give kind of work done during most of working life, even if retired <b>Orchardist</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME: <b>J Hooker Lewis</b>		14. MOTHER'S MAIDEN NAME: <b>Laura V. Kelbaugh</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY No.: <b>215-20-7863</b>	
17. INFORMANT & ADDRESS: <b>Donald L. Lewis Thurmont Md</b>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death	
442X Immediate cause (a) <b>Nephrosclerosis</b>		2 years	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <b>Hypertensive Cardiovascular Disease</b>		2 years	
(c) <b>Congestive Heart Failure</b>		1 month	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>14 Apr., 1955</b> , to <b>19 Apr., 1955</b> , that I last saw the deceased alive on <b>19 Apr., 1955</b> , and that death occurred at <b>10:20 P.M.</b> , from the causes and on the date stated above.			
SIGNATURE <b>Thomas C. Ste...</b>		ADDRESS <b>463 rd st</b>	
DATE SIGNED <b>22 April 1955</b>		DATE SIGNED <b>4-20-55</b>	
23. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		DATE THEREOF <b>Apr. 22. 1955</b>	
NAME OF CEMETERY OR CREMATORY <b>United Brethern Cem.</b>		LOCATION (City, town, or county) (State) <b>Thurmont Fredk Co. Md</b>	
DATE RECD BY LOCAL REGISTRAR <b>22 April 1955</b>		REGISTRAR'S SIGNATURE <b>Elizabell H. Heck.</b>	
24. FUNERAL DIRECTOR <b>M.L. Creager &amp; Son</b>		ADDRESS <b>Thurmont. MD</b>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
U. S. S.

APR 25 1955

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3655

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

03657  
Reg. Dist.

No. 131

<b>1. PLACE OF DEATH:</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b>			
COUNTY <u>FREDERICK</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>FREDERICK</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>FREDERICK</u>		LENGTH OF STAY (in this place) <u>16 YRS.</u>		CITY (If outside corporate limits write RURAL and give nearest town) <u>FREDERICK</u>		<u>11</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>115 W. FIFTH ST.</u>				STREET ADDRESS (If rural, give location) <u>115 W. FIFTH ST.</u>		<u>1</u>	
<b>3. NAME OF DECEASED:</b> (First) (Middle) (Last) (Type or Print) <u>CALVIN</u> <u>(NONE)</u> <u>LIDIE</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>APRIL 4, 1955</u>			
<b>5. SEX:</b> <u>MALE</u>	<b>6. COLOR OR RACE:</b> <u>WHITE</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):</b> <u>WIDOWER</u>	<b>8. DATE OF BIRTH:</b> <u>JULY 14, 1902</u>		<b>9. AGE last birthday:</b> <u>52</u> yrs.		<b>IF UNDER 1 YEAR</b> Months: Days: Hours: Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of work life, even if retired): <u>TRUCK DRIVER</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY:</b> <u>CITY</u>		<b>11. BIRTHPLACE</b> (State or foreign country): <u>MARYLAND</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME:</b> <u>COLEMAN J. LIDIE, SR.</u>				<b>14. MOTHER'S MAIDEN NAME:</b> <u>SALLY MORRISON</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service) <u>YES</u> <u>US NAVY 1919</u>		<b>16. SOCIAL SECURITY No.:</b> <u>217-10-9804</u>		<b>17. INFORMANT &amp; ADDRESS:</b> <u>COLEMAN J. LIDIE, JR., BROTHER</u> <u>208 S. CARROLLS ST., FREDERICK, MD.</u>			

<b>18. MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>  <u>MINS.</u>
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:</b>		
Immediate cause (a) <u>SHOTGUN WOUND OF CHEST</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)		
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>		

<b>19a. DATE OF OPERATION:</b>		<b>19b. MAJOR FINDING OF OPERATION:</b>		<b>20. AUTOPSY?</b> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
<b>21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>	<b>21b. PLACE</b> (Home, farm, factory, OF street, office bldg., etc., INJURY <u>HOME</u> )	<b>21c. (City or town)</b> (County) (State) <u>FREDERICK - FREDERICK - MARYLAND</u>		
<b>21d. TIME</b> (Month) (Day) (Year) (Hour) OF INJURY <u>APRIL 4, 1955 8:30 PM</u>	<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	<b>21f. HOW DID INJURY OCCUR?</b> <u>SHOT SELF - DESPONDENT-SUICIDE NOTE</u>		

**22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.**

**SIGNATURE** Robert J. Jurie, **CHIEF MEDICAL EXAMINER** **DATE SIGNED** April 7, 1955  
**M. D.** **DEPUTY MEDICAL EXAMINER** **ASSISTANT MEDICAL EXAM.**

<b>23. BURIAL, CREMATION, REMOVAL (Specify):</b> <u>Burial</u>	<b>DATE THEREOF</b> <u>April 9, 1955</u>	<b>NAME OF CEMETERY OR CREMATORY</b> <u>Mount Olivet Cemetery</u>	<b>LOCATION</b> (City, town, or county) (State) <u>Frederick, Maryland</u>
<b>DATE REC'D BY LOCAL REG.</b> <u>9 April 1955</u>	<b>REGISTRAR'S SIGNATURE</b> <u>Elizabeth B. Hersh</u>	<b>24. FUNERAL DIRECTOR</b> <u>C. E. Cline &amp; Son - 8 East Patrick Street</u> <u>Frederick, Maryland</u>	



3657

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>FREDERICK</u>		STATE <u>MARYLAND</u>		COUNTY <u>FREDERICK</u>		STATE <u>MARYLAND</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u>		LENGTH OF STAY (in this place) <u>15, Yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u>		STREET ADDRESS <u>115, RECORD, ST.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HOME FOR THE AGED</u>							
3. NAME OF DECEASED: (First) <u>SARAH</u> (Middle) <u>HELEN</u> (Last) <u>LYNARD</u>				4. DATE OF DEATH: (Month) <u>April</u> (Day) <u>11</u> (Year) <u>1955</u>			
5. SEX: <u>F</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>WIDOWED</u>		8. DATE OF BIRTH: <u>July 2, 1860</u>	
9. AGE last birthday: <u>96</u> yrs.		10. MONTHS: <u>11</u>		11. DAYS: <u>11</u>		12. HOURS: <u>11</u>	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Frederick County Maryland</u>	
13. FATHER'S NAME: <u>Howard G. Maynard</u>				14. MOTHER'S MAIDEN NAME: <u>Sarah Newton Chiswell</u>			
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.:		17. INFORMANT & ADDRESS: <u>Records of HOME FOR THE AGED, FREDERICK, MD.</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
151X Immediate cause (a) <u>Probable Carcinoma of Stomach</u>						<u>6-8 mos.</u>	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>DUE TO</u>							
(c)							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT SUICIDE BOMICIDE (Specify)		PLACE (Home, farm, factory, street, or office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 14, 1955</u> , to <u>14 Apr 1955</u> , that I last saw the deceased alive on <u>14 Apr 1955</u> , and that death occurred at <u>12 Noon</u> , from the causes and on the date stated above.							
SIGNATURE <u>Charles H. Conley, M.D.</u>		(Degree or title)		ADDRESS <u>Frederick, Md</u>		DATE SIGNED <u>4/15/55</u>	
23. BURIAL OR CREMATION, (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>April 15, 1955</u>		<u>CE R HILL CRY TORY</u>		<u>PRINCE GEORGES COUNTY, MD.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>15 April 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth L. Heck</u>		24. FUNERAL DIRECTOR <u>ROBERT E. DUFFY</u>		ADDRESS <u>FREDERICK, MD.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 1917

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3687

## CERTIFICATE OF DEATH

Reg. Dist. No. 130

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Frederick</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Frederick</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick-Rural-R.D.#6</u>	LENGTH OF STAY (in this place) <u>Years</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick-Rural-R.D.#6</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Bartonsville</u>		STREET ADDRESS <u>Bartonsville</u>	
3. NAME OF DECEASED: (Type or Print)		4. DATE OF DEATH:	
ROY EDWARD MEALEY		April 28, 1955	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>March 13, 1878</u>
9. AGE last birthday: <u>77</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>General Mds. Store Owner</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Charles Mealey</u>		14. MOTHER'S MAIDEN NAME: <u>Catherine Sheets</u>	
15. WAR DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS: <u>Miss Bertha Lare, Frederick, R.D.#6, Md.</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
(A) IMMEDIATE CAUSE			
(B) ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While at work or Not while at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Apr. 18, 1955</u> to <u>Apr. 28, 1955</u> that I last saw the deceased alive on <u>Apr. 25, 1955</u> and that death occurred at <u>1:30 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>4/29/1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. FUNERAL DIRECTOR ADDRESS	
<u>Burial</u>		<u>M. R. Etchison &amp; Son, Frederick, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>29 April 1955</u>		REGISTRAR'S SIGNATURE <u>Lucian K. Falconer</u>	

MARGIN RESERVE FOR BINDING

BUREAU V. E.

MAY 27 1955

RECORDED



03659

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3653

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Frederick</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Frederick</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		LENGTH OF STAY (in this place) Years		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>326 Park Avenue</b>				STREET ADDRESS (If rural give location) <b>326 Park Avenue</b>			
3. NAME OF DECEASED: (First) (Middle) (Last) <b>ROY CLEVELAND MICHAEL</b>				4. DATE (Month) (Day) (Year) OF DEATH: <b>April 19, 1955</b>			
5. SEX: <b>Male</b>	6. COLOR OR RACE: <b>White</b>	7. SINGLE, MARRIED, WIDOWED, <del>DIVORCED</del> . (Specify): <b>Married</b>	8. DATE OF BIRTH: <b>15 June 1881</b>	9. AGE last birthday: <b>73</b> yrs	IF UNDER 1 YEAR: Months	IF UNDER 1 YEAR: Days	IF UNDER 24 HRS: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Retired Farmer</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>Farm Owner</b>		11. BIRTHPLACE (State or foreign country): <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME: <b>Frederick A. Michael</b>				14. MOTHER'S MAIDEN NAME: <b>Alice J. Baker</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <b>No</b> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <b>214-10-3889</b>		17. INFORMANT & ADDRESS: <b>107 E. Church St., Russell L. Michael, Frederick, Md.</b>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <b>Unknown</b>		<b>4 days</b>
ANTECEDENT CAUSE (B) <b>Cerebral Thrombosis</b>		<b>4 days</b>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <b>Arteriosclerosis &amp; Diabetes Mellitus</b>		<b>One &amp; 1/2</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
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21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **April 10, 1950**, to **April 19, 1955**, that I last saw the deceased alive on **April 19, 1955**, and that death occurred at **6 A M**, from the causes and on the date stated above.

SIGNATURE: **B. D. Frederick** ADDRESS: **M. D. Frederick, Maryland** DATE SIGNED: **19 April 1955**

23. BURIAL, CREMATION, REMOVAL (SPECIFY): <b>Burial</b>	DATE THEREOF: <b>21 April 1955</b>	NAME OF CEMETERY OR CREMATORY: <b>Mount Olivet Cemetery</b>	LOCATION (City, town, or county) (State): <b>Frederick, Maryland</b>
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DATE REC'D BY LOCAL REGISTRAR: <b>19 April 1955</b>	REGISTRAR'S SIGNATURE: <b>Elizabeth G. Hark</b>	24. FUNERAL DIRECTOR ADDRESS: <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>
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MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

1911

3659

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Frederick</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Frederick</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>	LENGTH OF STAY (in this place) <u>67 Years</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Frederick Memorial Hospital</u>		STREET ADDRESS (If rural give location) <u>32 East Third Street</u>	
3. NAME OF DECEASED: (Type or Print) <u>EDWARD WASHINGTON MILLER</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>April 22, 1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. STATUS: <u>WIDOWED</u> (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>24 Oct 1867</u>
9. AGE last birthday: <u>87</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>John L. Miller</u>		14. MOTHER'S MAIDEN NAME: <u>Julia E. Shawn</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.: <u>None</u>	
17. INFORMANT & ADDRESS: <u>32 E. 3rd St.,</u> <u>Miss Elva Earle Miller, Frederick, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE <u>420.</u>		
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST		
(A) <u>Congestive Heart failure</u>	DUE TO	<u>1 week</u>
(B) <u>Arteriosclerotic Heart Disease</u>	DUE TO	<u>? yrs.</u>
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
<u>Anemia and Diabetes mellitus</u>		<u>? yrs.</u>

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/18, 1955, to 4/22, 1955, that I last saw the deceased alive on 4/22, 1955, and that death occurred at 9:30 P.M., from the causes and on the date stated above.

SIGNATURE <u>Henry V. Chase</u>	DATE SIGNED <u>25 April 1955</u>	ADDRESS <u>Frederick, Maryland</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>25 April 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>
LOCATION (City, town, or county) <u>Frederick, Maryland</u>		(State)

DATE REC'D BY LOCAL REGISTRAR <u>25 April 1955</u>	REGISTRAR'S SIGNATURE <u>Elizabeth G. Hack</u>	24. FUNERAL DIRECTOR <u>M. R. Etchison &amp; Son, Frederick, Maryland</u>
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MARGIN RESERVED FOR BINDING

BUREAU V. S.

APR

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3671

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

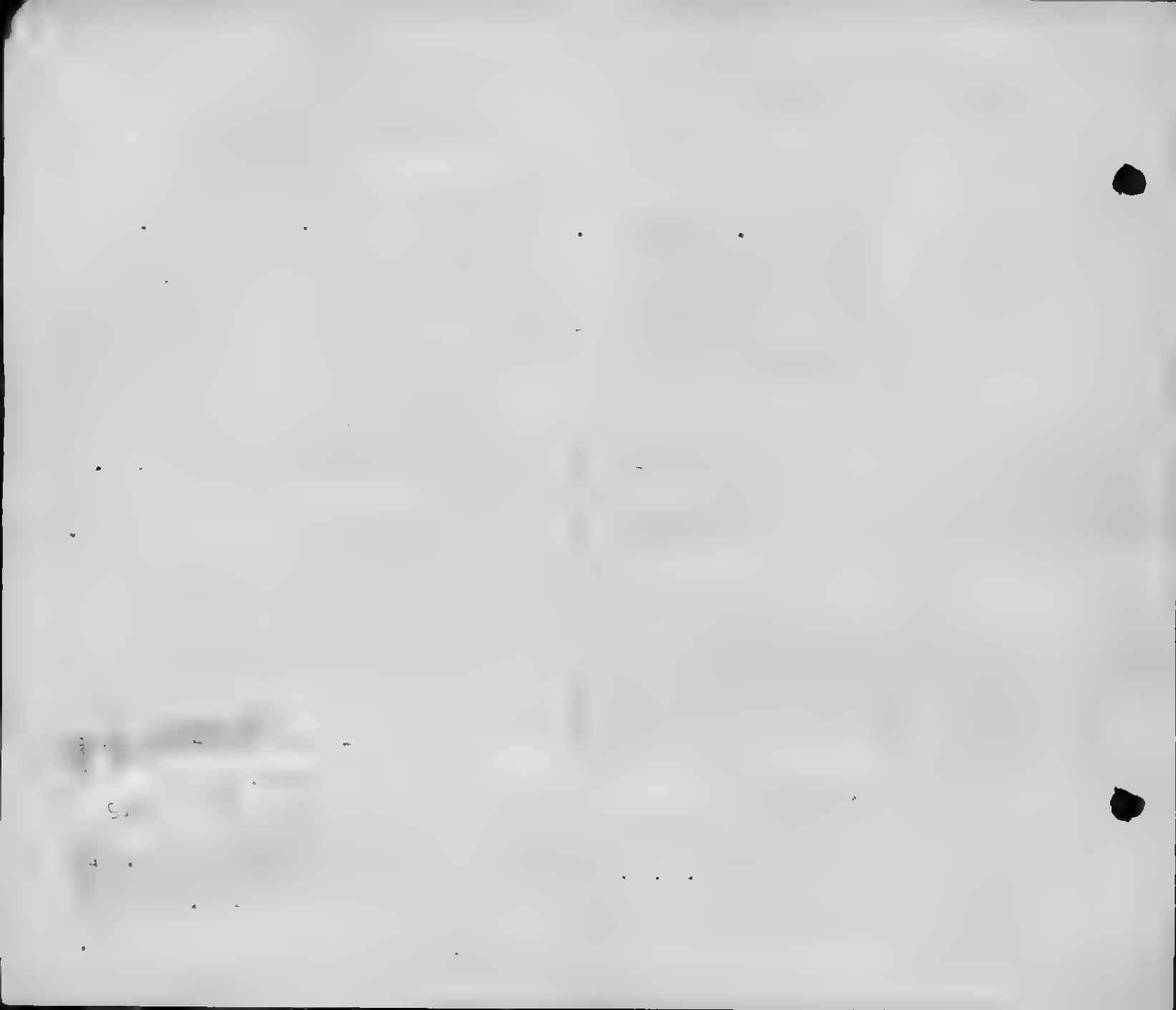
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 141

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Frederick</b>		MARYLAND		STATE <b>Maryland</b> COUNTY <b>Frederick</b>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
35 TOWN <b>Brunswick</b>				TOWN <b>Brunswick</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>West "B" St. at Dayton St.</b>				STREET ADDRESS (If rural, give location) <b>West "B" St. at Dayton St.</b>			
3. NAME OF DECEASED:				4. DATE OF DEATH			
(First) <b>Charles</b>		(Middle) <b>Leslie</b>		(Last) <b>Moats</b>		(Month) <b>April</b> (Day) <b>23</b> , (Year) <b>19 55</b>	
5. SEX: <b>Male</b>		6. COLOR OR RACE: <b>White</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, <b>Widowed</b>		8. DATE OF BIRTH: <b>8-20-1883</b>	
9. AGE last birthday: <b>71</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <b>Brakeman</b>		105. KIND OF BUSINESS OR INDUSTRY: <b>Railroad</b>		11. BIRTHPLACE (State or foreign country): <b>Maryland</b>	
13. FATHER'S NAME: <b>John Moats</b>				14. MOTHER'S MAIDEN NAME: <b>Alice V. Cline</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY No.: <b>705-05-7925</b>		17. INFORMANT & ADDRESS: <b>Douglas A. Moats, Silver Spring, Md.</b>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						Mins.	
Immediate cause (a) <b>Shotgun wound of chest</b> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <b>Home</b>		21c. (City or town) (County) (State) <b>Brunswick - Frederick - Maryland</b>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>April 23, 1955 6:30pm</b>				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>Shot by unknown person, shotgun</b>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <b>Robert J. Furie, M. D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>4-25-55</b> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM.			
23. BURIAL, CREMATION, REMOVAL <b>Burial</b>				DATE THEREOF <b>4-26-55</b>		NAME OF CEMETERY OR CREMATORY <b>Reformed</b>	
LOCATION City, town, or county (State) <b>Knoxville, Md.</b>							
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <b>Apr 26-55</b>				24. FUNERAL DIRECTOR <b>C.H. Feete and Bro. Brunswick, Md.</b>			

20. AUTOPSY?  
Yes ☒ No ☐



3660

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Frederick</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Frederick</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		LENGTH OF STAY (in this place) <b>Years</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>433 West Patrick Street</b>				STREET ADDRESS (If rural give location) <b>433 West Patrick Street</b>			
3. NAME OF DECEASED: (Type or Print) <b>FLORENCE MARGARET OLDFIELD</b>				4. DATE OF DEATH: <b>April 20, 19 55</b>			
5. SEX: <b>Female</b>		6. COLOR OR RACE: <b>White</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Widow</b>		8. DATE OF BIRTH: <b>July 22, 1911</b>	
				9. AGE last birthday <b>43</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10B. KIND OF BUSINESS OR INDUSTRY: <b>Laundry</b>		11. BIRTHPLACE (State or foreign country): <b>Maryland</b>	
						12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME: <b>William C. Smith</b>				14. MOTHER'S MAIDEN NAME: <b>Florence R. Eyer</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO: <b>579-30-1784</b>		17. INFORMANT & ADDRESS: <b>433 West Patrick St. Mrs. Florence R. Eyer, Frederick, Maryland</b>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<b>430.0</b>							
IMMEDIATE CAUSE (A) <b>arteriosclerotic heart disease</b>						<b>3 years</b>	
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>6-29</b> , 19 <b>53</b> , to <b>4-18</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>4-18</b> , 19 <b>55</b> , and that death occurred at <b>2:30 M.</b> from the causes and on the date stated above.							
SIGNATURE <b>[Signature]</b>				ADDRESS <b>Frederick, Maryland</b>		DATE SIGNED <b>4/21/1955</b>	
M. D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>Apr. 23, 1955</b>		<b>Mount Olivet Demetery</b>		<b>Frederick, Maryland</b>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<b>21 April 1955</b>		<b>[Signature]</b>		<b>M. R. Etchison &amp; Son, Frederick, Maryland</b>			

MARGIN RESERVED FOR BINDING

RECEIVED  
APR 22 1955



3661

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Frederick</b>		MARYLAND		STATE <b>Maryland</b> COUNTY <b>Frederick</b>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Frederick</b>		LENGTH OF STAY (In this place) <b>Years</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>112 East Street</b>				STREET ADDRESS (If rural give location) <b>112 East Street</b>			
3. NAME OF DECEASED: (First) (Middle) (Last) <b>MARTHA BEANER PALMER</b>				4. DATE (Month) (Day) (Year) OF DEATH: <b>April 18, 1955</b>			
5. SEX: <b>Female</b>		6. COLOR OR RACE: <b>Colored</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Widow</b>		8. DATE OF BIRTH: <b>February 11, 1889</b>	
				9. AGE last birthday <b>66</b> yrs		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Housework</b>				10b. KIND OF BUSINESS OR INDUSTRY: <b>Home</b>		11. BIRTHPLACE (State or foreign country): <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME: <b>Vincent Beaner</b>				14. MOTHER'S MAIDEN NAME: <b>Alice (Last Name Unknown)</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give year or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>No</b>			
17. INFORMANT & ADDRESS: <b>Maynard Palmer, 112 East Street, Frederick, Md.</b>							

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
199.9 IMMEDIATE CAUSE (A) <b>B. pneumonia</b>		<b>2 weeks</b>	
ANTECEDENT CAUSE (B) <b>Acute Pyelonephritis</b>		<b>2 weeks</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <b>Carcinomatosis</b>		<b>1 year</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)	21c. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **March 14, 1955**, to **18 Apr, 1955**, that I last saw the deceased alive on **18 Apr**, 1955, and that death occurred at **2:30 AM**, from the causes and on the date stated above.

SIGNATURE <b>Thomas E. Stone</b>	M. D. <b>Frederick, Maryland</b>	DATE SIGNED <b>4/18/1955</b>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	DATE THEREOF <b>Apr. 20, 1955</b>	NAME OF CEMETERY OR CREMATORY <b>St. Johns Cemetery</b>
		LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>
DATE REC'D BY LOCAL REGISTRAR <b>19 April 1955</b>	REGISTRAR'S SIGNATURE <b>Elizabeth B. Heck</b>	24. FUNERAL DIRECTOR ADDRESS <b>M. R. Etchsion &amp; Son, Frederick, Maryland</b>

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

8 11 1965

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3688

## CERTIFICATE OF DEATH

Reg. Dist. No. 131 ...

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Frederick</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Frederick</u>
<del>ED</del> (If outside corporate limits, write RURAL and give nearest town) OR <del>TOWN</del> <u>Adamstown-Rural R.D.#1,</u>	LENGTH OF STAY (In this place) <u>4 Years</u>	<del>CITY</del> (If outside corporate limits, write RURAL and give nearest town) OR <del>TOWN</del> <u>Adamstown-Rural R.D.#1,</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Near Doubbs</u>		STREET ADDRESS (If rural give location) <u>Near Doubbs</u>	
3. NAME OF DECEASED: (Type or Print)		4. DATE (Month) (Day) (Year)	
(First) <u>WILLIAM</u> (Middle) <u>PHILIP</u> (Last) <u>RANNEBERGER</u>		OF DEATH: <u>April</u> <u>1,</u> <u>1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. <del>SINGLE</del> <u>MARRIED</u> <del>WIDOWED</del> <u>DIVORCED</u> (Specify): <u>Widower</u>	8. DATE OF BIRTH: <u>May 24, 1867</u>
9. AGE last birthday <u>87</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Tenant</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Farm</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Robert S. Ranneberger</u>		14. MOTHER'S MAIDEN NAME: <u>Virginia Eader</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Elizabeth Hickman, Adamstown R.D.#1, Md.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
420.0 IMMEDIATE CAUSE (A) <u>Acute Congestive failure</u>			<u>24 hours</u>
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (B) <u>Arterio-sclerotic Heart dis./w</u>			<u>2 1/2 yrs.</u>
(C) <u>intermittent failure</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Cerebral Thrombosis</u>			<u>3 yrs</u>
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1951</u> , to <u>April</u> , 1955, that I last saw the deceased alive on <u>1 April</u> , 1955, and that death occurred at <u>11:20M</u> , from the causes and on the date stated above.		DATE SIGNED <u>4/3/1955</u>	
SIGNATURE <u>Charles H. Bailey</u>		ADDRESS <u>Frederick, Maryland</u>	
M.D. <u>Frederick, Maryland</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>April 14, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>		LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4 April 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth S. Hark</u>	
24. FUNERAL DIRECTOR <u>M. R. Etchison &amp; Son, Frederick, Maryland</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

WILLIAM V. E.

APR 7

1860

3662

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Frederick</i>	MARYLAND	STATE <i>Md.</i>	COUNTY <i>Fred.</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Frederick</i>	LENGTH OF STAY (in this place) <i>3 weeks</i>	CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Rural Frederick</i>	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Fred. Mem. Hospital</i>		STREET ADDRESS (If rural give location)	<i>1</i>
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <i>Howard</i>	(Middle) <i>E.</i>	(Last) <i>Riddlemoser</i>	(Month) <i>4</i> (Day) <i>8</i> (Year) <i>1955</i>
5. SEX: <i>male</i>	6. COLOR OR RACE: <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>widowed</i>	8. DATE OF BIRTH: <i>8-19-1877</i>
9. AGE last birthday: <i>77</i> yrs.		10. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <i>nightman, ret.</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>watchman</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>	
13. FATHER'S NAME: <i>Marion F. Riddlemoser</i>		14. MOTHER'S M maiden NAME: <i>Margaret Smith</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <i>218-24-1959</i>	
17. INFORMANT'S ADDRESS: <i>Charles E. Riddlemoser, Frederick, Md.</i>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			Interval Between Onset And Death
420.0 Immediate cause (a) <i>Congestive heart failure</i>			<i>1 month</i>
Antecedent causes (b) <i>arteriosclerotic heart disease</i>			<i>5 yrs +</i>
(c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Chronic Bronchitis</i>			<i>10 yrs +</i>
19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>3/21</i> , 1955, to <i>4/8</i> , 1955, that I last saw the deceased alive on <i>4/8</i> , 1955, and that death occurred at <i>9:30 AM</i> , from the causes and on the date stated above.			
SIGNATURE <i>Henry V. Chase M.D.</i>		ADDRESS <i>4 E Church St Frederick</i> DATE SIGNED <i>4/8/55</i>	
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<i>Burial</i>	<i>4-11-1955</i>	<i>Reformed Cemetery</i>	<i>Middletown Md.</i>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<i>11 April 1955</i>	<i>Elizabeth G. Hark</i>	<i>Gladhill Co.</i>	<i>Middletown, Md.</i>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>Frederick</b>	MARYLAND	STATE <b>md</b>	COUNTY <b>Frederick</b>
CITY (If outside corporate limits, write RURAL and give nearest town) <b>11 TOWN Frederick</b>	LENGTH OF STAY (in this place) <b>3 Mo</b>	CITY (If outside corporate limits, write RURAL and give nearest town) <b>TOWN Rural Thurmont</b>	<b>X</b>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Frederick Mem. Hospital</b>		STREET ADDRESS (If rural give location) <b>1</b>	
3. NAME OF DECEASED: (Type or Print)		4. DATE OF DEATH:	
<b>(First) Sarah (Middle) Elizabeth (Last) Ridenour</b>		<b>(Month) April (Day) 13 (Year) 1955</b>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:
<b>Female</b>	<b>White</b>	<b>Married</b>	<b>April 8th. 1904</b>
10a. USUAL OCCUPATION, Give kind of work done during most of working life, even if retired		10b. KIND OF BUSINESS OR INDUSTRY:	9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.
<b>Housewife</b>		<b>Own Home</b>	<b>51 yrs. Month. Days Hours Min.</b>
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<b>Thurmont R.D. Fredk Co.</b>		<b>U.S.A</b>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<b>Charles H. Grable</b>		<b>Harriette Ann Mumford</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or lack.)		16. SOCIAL SECURITY No.:	
<b>No</b>		<b>219-14-9487</b>	
17. INFORMANT & ADDRESS:		18. MEDICAL CERTIFICATION	
<b>Guy A. Ridenour Thurmont R.D. Md</b>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death
<b>416X Immediate cause</b>		<b>2-3 months</b>
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.		<b>10 yrs +</b>
(a) <b>Multiple emboli (arterial) to brain, arm, legs with gangrene</b>	DUE TO	
(b) <b>Rheumatic heart disease with auricular fibrillation and failure</b>	DUE TO	
(c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from <b>2/1</b> , 1955, to <b>4/13</b> , 1955, that I last saw the deceased alive on <b>4/13</b> , 1955, and that death occurred at <b>9:20 PM.</b> , from the causes and on the date stated above.			
SIGNATURE		ADDRESS	
<b>Henry V. Chase</b>		<b>48 Church St. Frederick</b>	
DATE SIGNED		DATE SIGNED	
<b>4/14/55</b>		<b>4/14/55</b>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF	
<b>Burial</b>		<b>Apr. 17th. 1955</b>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<b>United Brethren Cem.</b>		<b>Thurmont. Fredk Co. MD</b>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE	
<b>16 April 1955</b>		<b>Elizabeth B. Heck</b>	
24. FUNERAL DIRECTOR		ADDRESS	
<b>M.L. Creager &amp; Son</b>		<b>Thurmont. MD</b>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

EDMUND V. S.

APR



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist.

No. 131

## 1. PLACE OF DEATH:

COUNTY

FREDERICK

MARYLAND

~~CITY~~ (If outside corporate limits, write RURAL OR and give nearest town)

~~TOWN~~ RURAL-FREDERICK

LENGTH OF STAY (in this place)

LIFE

HOSPITAL OR INSTITUTION OR STREET ADDRESS

MT. PHILIP ROAD

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MARYLAND COUNTY FREDERICK

CITY (If outside corporate limits write RURAL and give nearest town)

~~TOWN~~ FREDERICK

STREET ADDRESS

(If rural, give location)  
 118 S. JEFFERSON ST.

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

CORNELIUS

HENRY

ROBERTS

4. DATE OF DEATH

(Month)

(Day)

(Year)

APRIL 1,

1955

## 5. SEX:

MALE

## 6. COLOR OR RACE:

WHITE

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

MARRIED

## 8. DATE OF BIRTH:

July 30, 1893

## 9. AGE last birthday:

61

yrs.

## IF UNDER 1 YEAR

Months Days

Hours Min.

## 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):

Farm

## 10b. KIND OF BUSINESS OR INDUSTRY:

Owner

## 11. BIRTHPLACE (State or foreign country):

Maryland

## 12. CITIZEN OF WHAT COUNTRY?

USA

## 13. FATHER'S NAME:

Henry Roberts

## 14. MOTHER'S MAIDEN NAME:

Cordelia Summers

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

No

## 16. SOCIAL SECURITY No.:

211-32-2619

## 17. INFORMANT &amp; ADDRESS:

118 South Jefferson St.

Mrs. Edna S. Roberts, Frederick, Maryland

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

(a).....

STRANGULATION BY HANGING

DUE TO

Antecedent cause(s)

(b).....

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(c)

INTERVAL BETWEEN ONSET AND DEATH

Ca 30'

## II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDING OF OPERATION:

## 20. AUTOPSY?

Yes ☐ No ☒

## 21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

## 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

## 21c. (City or town)

(County)

(State)

NR. FREDERICK - FREDERICK - MD.

## 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

APRIL 1, 1955 6:10 PM

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

## 21f. HOW DID INJURY OCCUR?

HUNG SELF IN PIG PEN ON FARM

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

SIGNATURE

Robert J. Furie,

CHIEF MEDICAL EXAMINER  
 DEPUTY MEDICAL EXAMINER  
 ASSISTANT MEDICAL EXAM.

DATE SIGNED  
 April 1, 1955

## 23. BURIAL, CREMATION, REMOVAL (Specify):

Burial

## DATE THEREOF

April 4, 1955

## NAME OF CEMETERY OR CREMATORY

Lutheran Cemetery

## LOCATION (City, town, or county)

Middletown, Maryland

(State)

## DATE REC'D BY LOCAL REG.

April 1955

## REGISTRAR'S SIGNATURE

Elizabeth B. Heh

## 24. FUNERAL DIRECTOR

M. R. Etchison &amp; Son, Frederick, Maryland

## ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

 03668  
 Reg. Dist.

No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>FREDERICK</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>FREDERICK</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
<u>11 TOWN FREDERICK</u>		<u>6 HRS.</u>		<u>TOWN FREDERICK</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>ODD FELLOWS HOME BLDG.</u>				STREET ADDRESS (If rural, give location) <u>26 W. SIXTH ST.</u>			
3. NAME OF DECEASED:				4. DATE OF DEATH			
(First) <u>ABERDEEN</u>		(Middle) <u>DUNN</u>		(Last) <u>ROBINSON</u>		(Month) (Day) (Year) <u>APRIL 18, 1955</u>	
(Type or Print)							
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):		8. DATE OF BIRTH:	
<u>MALE</u>		<u>NEGRO</u>		<u>MARRIED</u>		<u>MAR. 3, 1900</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>JANITOR LABORER</u>				<u>York - PA.</u>			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Unknown</u>				<u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
<u>yes</u>				<u>W.W.I</u>		<u>217-10-0261 Josephine M. Robinson 13 W. 5<sup>th</sup> St.</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>20.0 CORONARY ARTERY OCCLUSION</u> DUE TO						<u>MINS.</u>	
Antecedent cause(s) (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)						<u>YRS.</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)		21c. (City or town) (County)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (State)	
<u>CAUSE OF DEATH. NONE</u>							
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Robert J. Janie,</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>April 18, 1955</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM.			
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>4-22-55</u>		<u>Fair View</u>		<u>Frederick - Md.</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>21 April 1955</u>		<u>Elizabeth H. Webb</u>		<u>Charles E. Hicks III</u>		<u>Frederick-Md.</u>	

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. **03669**  
No. **139**

<b>1. PLACE OF DEATH:</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b>	
COUNTY <b>FREDERICK</b>	MARYLAND	STATE <b>Md</b>	COUNTY <b>Frederick</b>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>X TOWN RURAL - SABILLASVILLE</b>		CITY (If outside corporate limits write RURAL and give nearest town) <b>TOWN Sabillasville</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED: (First) <b>ALLEN</b> (Middle) <b>RUSSELL</b> (Last) <b>SMITH</b>		4. DATE OF DEATH (Month) <b>APRIL</b> (Day) <b>2</b> (Year) <b>1955</b>	
5. SEX: <b>MALE</b>	6. COLOR OR RACE: <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widowed</b>	8. DATE OF BIRTH: <b>Nov. 12 1896</b>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <b>carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY: <b>Construction</b>	9. AGE last birthday: <b>58</b> yrs. IF UNDER 1 YEAR: Months Days Hours Min.
11. BIRTHPLACE (State or foreign country): <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME: <b>Lewis Smith</b>		14. MOTHER'S MAIDEN NAME: <b>Emma Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>No</b> (If Yes, give war or dates of service) <b>20</b>		16. SOCIAL SECURITY No.: <b>198-01-5802</b>	
17. INFORMANT & ADDRESS: <b>Allen F. Smith Frederick R.D. Md</b>			

<b>18. MEDICAL CERTIFICATION</b>	
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:</b> <b>776X</b> Immediate cause (a) <b>GUNSHOT WOUND OF HEAD</b> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause <b>DUE TO</b> stating underlying cause last (c)	INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b>

**II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.**

19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town, (County) (State) <b>NR. SABILLASVILLE - FREDERICK - MD.</b>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>Ca APRIL 2, 1955 noon</b>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>SHOT SELF IN HEAD WITH .22 cal RIFLE</b>			

**22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.**

SIGNATURE **Robert J. Jamie,** CHIEF MEDICAL EXAMINER ☐ DATE SIGNED **Apr. 3, 1955**  
M. D. DEPUTY MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAM. ☐

23. BURIAL, CREMATION, REMOVAL (Specify): <b>Burial</b>	DATE THEREOF: <b>April 5th, 1955</b>	NAME OF CEMETERY OR CREMATORY: <b>Bethel Church of God. Cascade. Fredk Co. MD</b>	LOCATION (City, town, or county) (State): <b>MD</b>
DATE REC'D BY LOCAL REG. <b>4/5/55</b>	REGISTRAR'S SIGNATURE: <b>J. D. Lyon</b>	24. FUNERAL DIRECTOR ADDRESS: <b>M. L. Creager &amp; Son. Thurmont. Md</b>	

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## CERTIFICATE OF DEATH

Reg. Dist. No. 81

## 1. PLACE OF DEATH:

COUNTY Fredrick MARYLAND  
 CITY (If outside corporate limits, write RURAL LENGTH OF STAY OR and give nearest town) Woodlawn Rural 4 years  
 HOSPITAL OR INSTITUTION OR STREET ADDRESS near Johnsville

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

CITY (If outside corporate limits, write RURAL and give nearest town) Woodlawn Rural X  
 STREET ADDRESS (If rural give location) near Johnsville 1

## 3. NAME OF DECEASED:

(First) (Middle) (Last)  
MARY ELIZABETH STONER

## 5. SEX:

Female

## 5. COLOR OR RACE:

White

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

widowed

## 8. DATE OF BIRTH:

12/10/1871

## 4. DATE OF DEATH:

(Month) (Day) (Year)  
April 10 1955

## 9. AGE last birthday:

83 yrs.

## IF UNDER 1 YEAR IF UNDER 24 HRS

Months Days Hours Min.

## 10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired)

housewife

## 10b. KIND OF BUSINESS OR INDUSTRY:

at home

## 11. BIRTHPLACE (State or foreign country):

Maryland

## 12. CITIZEN OF WHAT COUNTRY?

U. S.

## 13. FATHER'S NAME:

Adam Fries

## 14. MOTHER'S MAIDEN NAME:

Elizabeth Woods

## 15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)

no

## 16. SOCIAL SECURITY No.:

none

## 17. INFORMANT &amp; ADDRESS:

R. Stoner, Woodlawn Rural Md.

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

430.1

Immediate cause

(a) Crown an Thrombosis

DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) Brain an Atheria

DUE TO

(c)

Interval Between Onset And Death

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION:

4/13/55

## 19b. MAJOR FINDINGS OF OPERATION

none

## 20. AUTOPSY?

Yes ☐ No ☐

## 21. ACCIDENT SUICIDE HOMICIDE (Specify)

none

## PLACE (Home, farm, factory, street, or office bldg., etc.)

at home

## (CITY OR TOWN)

Woodlawn

## (COUNTY)

Frederick

## (STATE)

Md.

## TIME (Month) (Day) (Year) (Hour) OF INJURY

April 10 1955 10:30 AM

## INJURY OCCURRED

While at Work ☐ Not While at Work ☐

## HOW DID INJURY OCCUR?

fall from bridge22. I hereby certify that I attended the deceased from April 10, 1955 to April 10, 1955 that I last saw the deceasedon April 10, 1955 and that death occurred at 10:30 AM from the causes and on the date stated above.SIGNATURE E. H. Mason M.D. ADDRESS Elmow Bridge, Md. DATE SIGNED April 11, 1955

## 23. BURIAL, CREMATION, REMOVAL (Specify)

burial

## DATE THEREOF

4/13/55

## NAME OF CEMETERY OR CREMATORY

Pipe Creek Cem.

## LOCATION (City, town, or county)

Carroll County, Md.

## (State)

Md.

## DATE RECD BY LOCAL REGISTRAR

April 11, 1955

## REGISTRAR'S SIGNATURE

Lellie Kapp

## 24. FUNERAL DIRECTOR

R. & Haynes & Sons

## ADDRESS

Elmow Bridge, Md.

MARGIN RESERVED FOR BINDING

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3665

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Frederick</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Frederick</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>	LENGTH OF STAY (in this place) <u>30 Years</u>	If outside corporate limits, write RURAL and give nearest town) <u>Frederick-Rural R.F.D.#2,</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>708 North Market Street</u>		STREET ADDRESS (If rural give location) <u>On Route U.S.#240</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>ANNIE</u>	(Middle) <u>KATE</u>	(Last) <u>SWOMLEY</u>	
5. SEX: <u>Female</u>		6. DATE OF DEATH: <u>April 30, 1955</u>	
6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widow</u>	8. AGE last birthday: <u>88</u> yrs	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housework</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Home</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>William Henry Kemp</u>		14. MOTHER'S MAIDEN NAME: <u>Henrietta Brengle</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.): <u>No</u> (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Merle C. Kepler, Middletown, Maryland</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Primary thrombosis</u>		<u>2 1/2 hrs</u>	
ANTECEDENT CAUSE (B) <u>Arteriosclerosis</u>		<u>5 1/2 hrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>April 29, 1955</u> , to <u>April 30, 1955</u> , that I last saw the deceased alive on <u>April 29, 1955</u> , and that death occurred at <u>7:50 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>E. H. H. H.</u>		DATE SIGNED <u>5/1/55</u>	
ADDRESS <u>Frederick, Maryland</u>			
M. D.			
23. BURIAL CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
<u>Burial</u>		<u>May 2, 1955</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Mount Olivet Cemetery</u>		<u>Frederick, Maryland</u>	
24. FUNERAL DIRECTOR		ADDRESS	
<u>M. R. Etchison &amp; Son, Frederick, Maryland</u>			
DATE REC'D BY LOCAL REGISTRAR <u>2 May 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth G. H. H.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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## CERTIFICATE OF DEATH

Reg. Dist. No. 131

Item 2, Film G181 5-16-55 et

1 PLACE OF DEATH:				2 USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Frederick	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frederick		LENGTH OF STAY (in this place) 1 year		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frederick Buckeystown			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Montevue County Home				STREET ADDRESS Montevue County Home			
3. NAME OF DECEASED: (First) RICHARD		(Middle)		(Last) THOMAS		4. DATE OF DEATH: April 2 19 55	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed	8. DATE OF BIRTH: August 18, 1876	9. AGE last birthday: 78 yrs.	10. IF UNDER 1 YEAR: Months Days	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Merchant		10b. KIND OF BUSINESS OR INDUSTRY: General Merchandise		11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Otho Thomas				14. MOTHER'S MAIDEN NAME: Mary Jane Bready			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY No.: None		17. INFORMANT & ADDRESS: Mr. Edgar Thomas - Jefferson, Maryland			
18. MEDICAL CERTIFICATION							Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 422.2 Immediate cause Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (a) Pulmonary Edema (b) Chronic myocarditis (c)							4 days 2 yrs.
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1952, to Apr 2, 1955, that I last saw the deceased alive on Apr 2, 1955, and that death occurred at 9:30 a.m., from the causes and on the date stated above. SIGNATURE J. McKee M.D. DATE SIGNED							
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		April 4, 1955		Mount Olivet Cemetery		Frederick, Maryland	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR			
4 April 1955		Elizabeth G. Herb		C. E. Cline & Son - 8 East Patrick Street Frederick, Maryland			

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

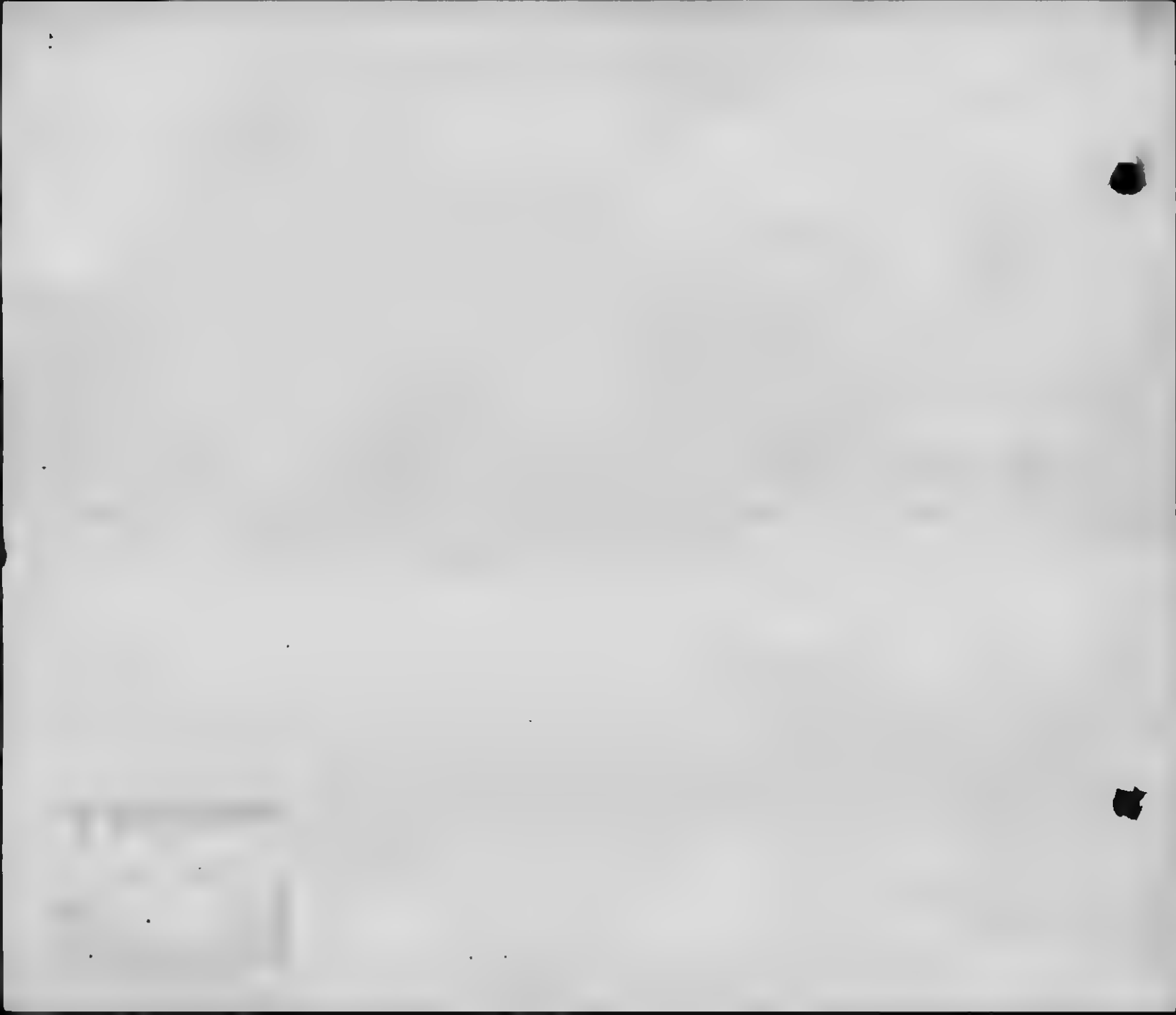
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 38

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>FREDERICK</b>		MARYLAND		STATE <b>TENN.</b>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
<b>X</b> TOWN <b>RURAL-NEW MARKET</b>		<b>TRANSIENT</b>		TOWN <b>FOUNTAIN HEAD 79X-2</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>OLD RTE 40</b>				STREET ADDRESS (If rural, give location) <b>ROUTE 1</b>			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
(First) <b>LEWELL</b> (Middle) <b>HARRISON</b> (Last) <b>TOMLINSON</b>				(Month) <b>APRIL</b> (Day) <b>7</b> (Year) <b>1955</b>			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
<b>MALE</b>		<b>WHITE</b>		<b>SINGLE</b>		<b>FEB. 21, 1931</b>	
9. AGE last birthday:		10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<b>24</b> yrs.		<b>SOLDIER</b>		<b>U.S. ARMY</b>		<b>Kentucky</b>	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME:			
				<b>Blonnie Andrew Tomlinson</b>			
14. MOTHER'S MAIDEN NAME:				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give year or dates of service)			
<b>Nannie Belle Rogers</b>				<b>Oct 1952 to Aug 1954</b>			
16. SOCIAL SECURITY No.:				17. INFORMANT & ADDRESS:			
<b>Unknown</b>				<b>Service Record, Camp Detrick, Frederick, Md.</b>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH.						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) ... <b>FRACTURED SKULL</b>						... <b>INST.</b>	
DUE TO							
Antecedent cause(s) (b) ...							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <b>Highway</b> )		21c. (City or town) (County) (State)		21d. HOW DID INJURY OCCUR?	
				<b>NR. NEW MARKET-FREDERICK-MD.</b>		<b>AUTO IN WHICH PASSENGER LEFT HIGHWAY &amp; OVERTURNED</b>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>APRIL 7, 1955 12am.</b>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>					
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <b>Robert J. Jurie,</b>				M. D. <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>ASSISTANT MEDICAL EXAM.</b> <input type="checkbox"/>			
DATE SIGNED <b>Apr. 7, 1955</b>							
23. BURIAL, CREMATION, REMOVAL (Specify): <b>Burial</b>		DATE THEREOF <b>11 Apr 1955</b>		NAME OF CEMETERY OR CREMATORY <b>Link Cemetery</b>		LOCATION (City, town, or county) (State) <b>Near Portland, Tenn.</b>	
DATE REC'D BY LOCAL REG <b>April 8-1955</b>		REGISTRAR'S SIGNATURE <b>Lucian K. Fokum</b>		24. FUNERAL DIRECTOR <b>M. R. Etchison and Son, Frederick, Md.</b>			
ADDRESS							

03673



3666

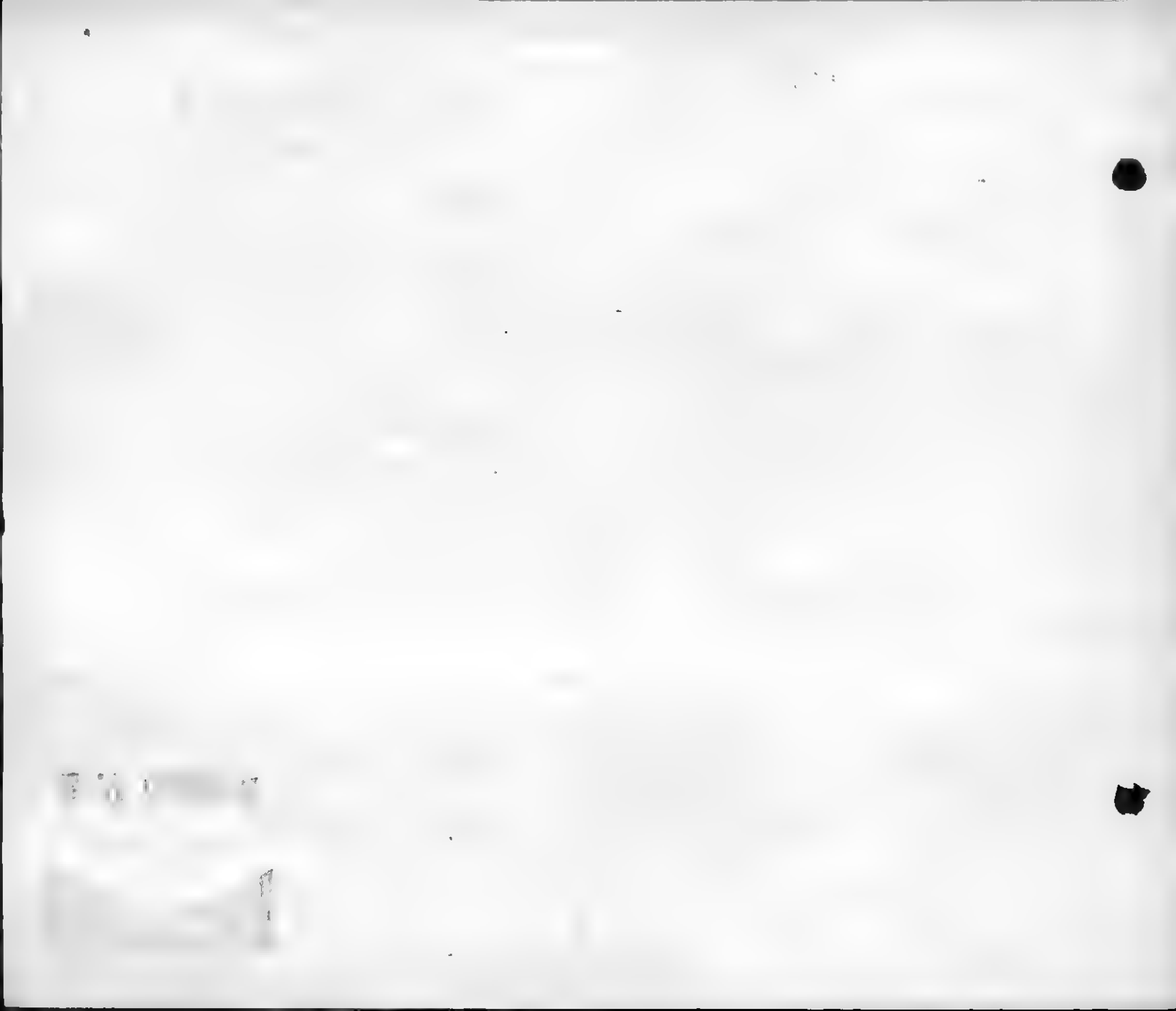
## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Frederick	
CITY (If outside corporate limits, write OR and give nearest town) Frederick		RURAL LENGTH OF STAY (in this place) 33 years		CITY (If outside corporate limits, write OR and give nearest town) Frederick			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 110 Monroe Street				STREET ADDRESS (If rural give location) 110 Monroe Street			
3. NAME OF DECEASED: (First) JOHN		(Middle)		(Last) VAN ACORE		4. DATE OF DEATH: April 4, 1955	
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married		8. DATE OF BIRTH: May 23, 1894	
9. AGE last birthday: 60 yrs.		IF UNDER 1 YEAR: Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Electrician				10b. KIND OF BUSINESS OR INDUSTRY: Railroad		11. BIRTHPLACE (State or foreign country): Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME: Nathan Van Acore				14. MOTHER'S MAIDEN NAME: Harriet Van Acore			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes				16. SOCIAL SECURITY No.: W. War I		17. INFORMANT & ADDRESS: Mrs. John Van Acore - 110 Monroe Street, Frederick, Maryland	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.2 Immediate cause (a) ...							
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) ...							
(c) ...							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION							
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from ... 1956, to April 4, 1955, that I last saw the deceased alive on April 4, 1955, and that death occurred at 1:10 P.M., from the causes and on the date stated above.							
SIGNATURE				ADDRESS		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		April 7, 1955		Mount Olivet Cemetery		Frederick, Maryland	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
6 April 1955		Elizabeth G. Heck		C. E. Cline & Son - 8 East Patrick Street		Frederick, Maryland	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the names of death clearly and legibly.





3683

## CERTIFICATE OF DEATH

Reg. Dist. No. 134

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Frederick</i>		MARYLAND		STATE <i>md</i>		COUNTY <i>Frederick</i>	
CITY (If outside corporate limits, write and give nearest town) <i>Emmitsburg</i>		LENGTH OF STAY (In this place) <i>10</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Emmitsburg</i>		OR TOWN <i>x</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <i>1</i>			
3. NAME OF DECEASED: (First) <i>ROBERT</i> (Middle) <i>B</i> (Last) <i>WALTER</i>				4. DATE (Month) <i>April</i> (Day) <i>14</i> (Year) <i>1955</i>			
5. SEX: <i>M</i>		6. COLOR OR RACE: <i>white</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Married</i>		8. DATE OF BIRTH: <i>Feb 8-1860</i>	
9. AGE last birthday: <i>95</i>		IF UNDER 1 YEAR: Months <i>0</i> Days <i>0</i>		IF UNDER 24 HRS: Hours <i>0</i> Min. <i>0</i>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter, Carpenter</i>				10B. KIND OF BUSINESS OR INDUSTRY: <i>Carpenter</i>		11. BIRTHPLACE (State or foreign country): <i>Emmitsburg md</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>							
13. FATHER'S NAME: <i>John Walter</i>				14. MOTHER'S MAIDEN NAME: <i>Mary Hoffs</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>no</i> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>no</i>		17. INFORMANT & ADDRESS: <i>McKelli Walter Emmitsburg</i>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
4321 IMMEDIATE CAUSE (A) <i>acute myocardial failure</i>						<i>1 day</i>	
ANTECEDENT CAUSE (S) DUE TO (B) <i>arteriosclerotic cardiovascular disease</i>						<i>several years</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Jan 45</i> , 19 <i>55</i> , to <i>Apr 14</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>July 4</i> , 19 <i>55</i> , and that death occurred at <i>530p</i> , from the causes and on the date stated above.							
SIGNATURE: <i>W.R. Cadle</i>		ADDRESS: <i>Emmitsburg Md</i>		DATE SIGNED: <i>4-15-55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF: <i>Apr 18-1955</i>		NAME OF CEMETERY OR CREMATORY: <i>St Marys Cmn</i>		LOCATION (City, town, or county) (State): <i>Barnesville Md Co Md</i>	
DATE REC'D BY LOCAL REGISTRAR: <i>Apr 16-1955</i>		REGISTRAR'S SIGNATURE: <i>M.L. Shuff</i>		24. FUNERAL DIRECTOR: <i>M.L. Oregan</i>		ADDRESS: <i>San Thurmont</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3667

## CERTIFICATE OF DEATH

Reg. Dist. No. 13

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Frederick</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<u>Frederick</u>		<u>weeks</u>		<u>Johnsville</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>DR EDWARD AUGUSTUS WARNER</u>				<u>April 29 1955</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>M</u>		8. DATE OF BIRTH: <u>Aug 2 - 1871</u>	
				9. AGE last birthday <u>83</u> yrs		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Veterinarian</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
13. FATHER'S NAME: <u>John Thomas Warner</u>				14. MOTHER'S MAIDEN NAME: <u>Lidia Etter</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>none</u>				16. SOCIAL SECURITY NO. <u>none</u>			
17. INFORMANT & ADDRESS: <u>Ralph A. Warner, Johnsville, Md.</u>				18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
420.0 IMMEDIATE CAUSE				(A) <u>Arteriosclerosis</u>			
ANTECEDENT CAUSE (B)				DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(B) <u>Diabetes</u>			
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>P - 10</u>							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>1953</u> , to <u>1955</u> , that I last saw the deceased alive on <u>4-29</u> , 19 <u>55</u> , and that death occurred at <u>6:55</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>Elizabeth Hebe</u>				DATE SIGNED			
M.D. <u>Elizabeth Hebe</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>May 2 - 1955</u>		<u>Methodist</u>		<u>Johnsville Md</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>2 May 1955</u>		<u>Elizabeth Hebe</u>		<u>Dr. Hartley's home, Union Bridge, Md</u>			

U. S. DEPARTMENT OF AGRICULTURE

OFFICE OF THE  
SECRETARY

3668

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>Frederick</b>	MARYLAND	STATE <b>Virginia</b>	COUNTY <b>Loudoun</b>
CITY (If outside corporate limits, write RURAL or and give nearest town) <b>Frederick</b>	LENGTH OF STAY (in this place) <b>9 Days</b>	OR TOWN <b>Lovettsville</b> <b>83X-3</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Frederick Memorial Hospital</b>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (First) (Middle) (Last) <b>LAURA ELMA WERKING</b>		4. DATE (Month) (Day) (Year) OF DEATH: <b>April 13, 1955</b>	
5. SEX: <b>Female</b>	6. COLOR OR RACE: <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Single</b>	8. DATE OF BIRTH: <b>11 Oct 1889</b>
9. AGE last birthday: <b>65</b> yrs.		10. IF UNDER 1 YEAR: Months Days	11. IF UNDER 24 HRS: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life) <b>Retired Telephone Operator</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>Telephone Co.</b>	
11. BIRTHPLACE (State or foreign country): <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME: <b>Robert Werking</b>		14. MOTHER'S MAIDEN NAME: <b>Annie Werking</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.: <b>Unknown</b>	
17. INFORMANT & ADDRESS: <b>Hospital Records</b>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <b>Uremia</b>		<b>2 wks.</b>	
ANTECEDENT CAUSE (B) <b>Hypertensive cardiovascular disease</b>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <b>malignant type</b>		<b>2 yrs.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. TIME (Month) (Day) (Year) (Hour) OF INJURY		21F. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <b>4/6, 1955</b> , to <b>4/13, 1955</b> that I last saw the deceased alive on <b>4/13, 1955</b> , and that death occurred at <b>11 A M.</b> from the causes and on the date stated above.			
SIGNATURE <b>Henry V. Chase M.D.</b>		DATE SIGNED <b>13 April 1955</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>15 April 1955</b>	
NAME OF CEMETERY OR CREMATORY <b>Union Cemetery</b>		LOCATION (City, town, or county) (State) <b>Lovettsville, Virginia</b>	
DATE REC'D BY LOCAL REGISTRAR <b>11 April 1955</b>		REGISTRAR'S SIGNATURE <b>Elizabeth B. Hach</b>	
24. FUNERAL DIRECTOR <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		ADDRESS	

MARGIN RESERVE FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 5 1976

MS-105

3669

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Frederick</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>Fred</i>	
CITY (If outside corporate limits, write OR and give nearest town) <i>Frederick</i>		RURAL LENGTH OF STAY (in this place) <i>2 days</i>		CITY (If outside corporate limits, write OR and give nearest town) <i>Thurmont</i>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Frederick Memorial Hospital</i>				STREET ADDRESS (If rural give location) <i>1</i>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<i>EDITH BLACK WHITMORE</i>				<i>April 10 1955</i>			
5. SEX: <i>Female</i>		6. COLOR OR RACE: <i>White</i>		7. <del>SINGLE, MARRIED, WIDOWED, DIVORCED.</del> (Specify) <i>Widowed</i>		8. DATE OF BIRTH: <i>MAR 11 - 1869</i>	
9. AGE last birthday: <i>86</i> yrs.		10. MONTHS <i>8</i>		11. DAYS <i>6</i>		12. HOURS <i>0</i> MIN.	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY: <i>Own Home</i>			
11. BIRTHPLACE (State or foreign country): <i>Rocky Ridge, Fred. Md.</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME: <i>Joseph H. Black</i>				14. MOTHER'S MAIDEN NAME: <i>MATILDA NORRIS</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>—</i>				16. SOCIAL SECURITY No.: <i>none</i>			
(If Yes, give war or dates of service)				17. INFORMANT & ADDRESS: <i>Rev C. H. Corbett, Thurmont, Md</i>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
<i>586X</i>						<i>7 days</i>	
Immediate cause (a) <i>Generalized Peritonitis</i>						<i>7 days</i>	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <i>Perforated Infected Gall Bladder</i>						<i>7 days</i>	
(c)							
11. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <i>4/9/55</i>				19b. MAJOR FINDINGS OF OPERATION: <i>Generalized Peritonitis; Perforated Gall Bladder; Stenosis</i>			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
		INJURY					
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
		m.					
22. I hereby certify that I attended the deceased from <i>4/7/55</i> , 19 <i>55</i> , to <i>4/10</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>4/9</i> , 19 <i>55</i> , and that death occurred at <i>9:00 AM</i> , from the causes and on the date stated above.							
SIGNATURE <i>E. L. Robbins</i>				ADDRESS <i>Frederick Md.</i>			
DATE SIGNED <i>4/11/55</i>							
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>CREMATION</i>		<i>Apr. 14, 1955</i>		<i>Cedar Hill</i>		<i>WASHINGTON D.C.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>11 April 1955</i>		REGISTRAR'S SIGNATURE <i>Elinor L. Heck</i>		24. FUNERAL DIRECTOR <i>M. L. Creager &amp; Son, Thurmont, Md</i>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Proc. McIntosh

BUREAU V. S.

APR 13 1955

RECEIVED



PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03679

3670

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Frederick</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Frederick</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>11 Frederick</i>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <i>OR Middletown</i>		<i>X</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>69 Fred. Mem. Hospital</i>				STREET ADDRESS (If rural give location) <i>1</i>			
3. NAME OF DECEASED: (Type or Print) <i>Charles O. Zeigler</i>				4. DATE OF DEATH: <i>4 8 1955</i>			
5. SEX: <i>male</i>		6. COLOR OR RACE: <i>white</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>married</i>		8. DATE OF BIRTH: <i>7-11-1888</i>	
9. AGE last birthday: <i>66</i> yrs.		10. AGE last birthday: If UNDER 1 YEAR		11. BIRTHPLACE (State or foreign country): <i>Pa.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <i>plumber</i>				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
13. FATHER'S NAME: <i>Abraham Zeigler</i>				14. MOTHER'S MAIDEN NAME: <i>Susan Oberlander</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>no</i>				16. SOCIAL SECURITY No.: <i>217-32-5169</i>		17. INFORMANT & ADDRESS: <i>Mrs. Blanche Zeigler, Middletown, Md.</i>	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
<i>463x Immediate cause</i>						<i>20 min.</i>	
(a) <i>Pulmonary embolus</i>							
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.						(b) <i>Phlebothrombosis rt femoral vein</i>	
						(c) <i>Undetermined</i>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Chronic duodenal ulcer.</i>							
19a. DATE OF OPERATION: <i>4 April 1955</i>				19b. MAJOR FINDINGS OF OPERATION: <i>Chronic stenosing duodenal ulcer.</i>			
20. AUTOPSY ? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR ?			
22. I hereby certify that I attended the deceased from <i>3 April, 1955</i> , to <i>8 April, 1955</i> , that I last saw the deceased alive on <i>8 April, 1955</i> , and that death occurred at <i>11:20 p.m.</i> , from the causes and on the date stated above.							
SIGNATURE <i>McHine E. Lea M.D.</i>				DATE SIGNED <i>9 April 55</i>			
ADDRESS <i>35 E. Church St., Frederick, Md.</i>							
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>4-11-1955</i>		<i>Reformed Cemetery</i>		<i>Middletown, Md.</i>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<i>11 April 1955</i>		<i>Elizabeth B. Heib</i>		<i>Gladhill Co., Middletown, Md.</i>			

RECEIVED

APR 12 1955

BUREAU V. S.